MEDICARE HOME HEALTH CARE, SKILLED NURSING FACILITY, AND OTHER POSTACUTE CARE PAYMENT POLICIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

MARCH 4, 1997

Serial 105–5

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

42–509 CC WASHINGTON : 1997

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-055959-6

COMMITTEE ON WAYS AND MEANS

BILL ARCHER, Texas, *Chairman*

PHILIP M. CRANE, Illinois
BILL THOMAS, California
E. CLAY SHAW, JR., Florida
NANCY L. JOHNSON, Connecticut
JIM BUNNING, Kentucky
AMO HOUGHTON, New York
WALLY HERGER, California
JIM McCRERY, Louisiana
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
JIM NUSSLE, Iowa
SAM JOHNSON, Texas
JENNIFER DUNN, Washington
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
PHILIP S. ENGLISH, Pennsylvania
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska
WES WATKINS, Oklahoma
J.D. HAYWORTH, Arizona
JERRY WELLER, Illinois
KENNY HULSHOF, Missouri

CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ROBERT T. MATSUI, California
BARBARA B. KENNELLY, Connecticut
WILLIAM J. COYNE, Pennsylvania
SANDER M. LEVIN, Michigan
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
RICHARD E. NEAL, Massachusetts
MICHAEL R. McNULTY, New York
WILLIAM J. JEFFERSON, Louisiana
JOHN S. TANNER, Tennessee
XAVIER BECERRA, California
KAREN L. THURMAN, Florida

A.L. SINGLETON, *Chief of Staff*
JANICE MAYS, *Minority Chief Counsel*

SUBCOMMITTEE ON HEALTH

BILL THOMAS, California, *Chairman*

NANCY L. JOHNSON, Connecticut
JIM McCRERY, Louisiana
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska
PHILIP M. CRANE, Illinois
AMO HOUGHTON, New York
SAM JOHNSON, Texas

FORTNEY PETE STARK, California
BENJAMIN L. CARDIN, Maryland
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
XAVIER BECERRA, California

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Ways and Means are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

MEDICARE HOME HEALTH CARE, SKILLED NURSING FACILITY, AND OTHER POST-ACUTE CARE PAYMENT POLICIES

TUESDAY, MARCH 4, 1997

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 1:08 p.m., in room 1310, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 25, 1997
No. HL–3

CONTACT: (202) 225–3943

Thomas Announces Hearing on Medicare Home Health Care, Skilled Nursing Facility, and Other Post-Acute Care Payment Policies

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on Medicare home health care, skilled nursing facility, and other post-acute care payment policy. The hearing will take place on Tuesday, March 4, 1997, in room 1310 Longworth House Office Building, beginning at 1:00 p.m.

In view of the limited time available to hear witnesses, oral testimony will be heard from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Medicare payments to post-acute care providers continue to be the fastest growing component of the Medicare program. Medicare home health care and skilled nursing facility payments have each increased, on average, by more than 30 percent per year since 1990. High rates of growth are fueled by Medicare's payment policies which provide few incentives for post-acute care providers to provide services more efficiently and reduce costs. While Medicare has modified its policies over the years to address payment per unit of service, it has had little success controlling the volume of services delivered.

For more than a decade, Congress has directed the Secretary of Health and Human Services to establish a prospective payment system for both home health care and skilled nursing facility services. Most recently, the vetoed Balanced Budget Act of 1995 included new policies that would have implemented separate prospective payment systems for both of these services. The President's fiscal year 1998 budget proposal contains provisions to establish prospective payment systems for these services as well as a number of initiatives to prevent fraud and abuse in the provisions of home health care and skilled nursing facility services.

Medicare rehabilitation facility and long-term care hospital admissions and payments have also risen in recent years. The vast majority of the patients in these facilities have a prior acute inpatient admission before entering the facility. These post-acute care services are paid under a system established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). In the Omnibus Budget Reconciliation Act of 1990, the Secretary was instructed to reform the TEFRA system or replace it with a prospective payment system. There has been little progress in this area.

In announcing the hearing, Chairman Thomas stated: "I am confident this is the year we will finally establish prospective payment systems for home health care and

skilled nursing facilities. The Congress, the Administration and the provider communities should work to develop new payment systems with incentives that ensure that Medicare beneficiaries have access to medically appropriate care that is cost-effective."

FOCUS OF THE HEARING:

This hearing will focus on the provisions in the President's fiscal year 1998 budget proposal regarding Medicare payments for home health care, skilled nursing facility, and other post-acute care services. These proposals will be assessed in light of the recommendations developed for the Congress by the Prospective Payment Assessment Commission, as well as the policies contained in the Medicare Preservation Act of 1995 and the Balanced Budget Act of 1995.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement and a 3.5-inch diskette in WordPerfect or ASCII format, with their address and date of hearing noted, by the close of business, Tuesday, March 18, 1997, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on a 3.5-inch diskette in WordPerfect or ASCII format.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS_MEANS/'.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–225–1904 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman THOMAS. The Subcommittee will come to order. In the spirit of bipartisanship, I have been told I can begin. [Laughter.]

I am beginning to think that maybe we ought to return to the old ways so I do not have to do all the lifting.

Today's hearing will focus on two of Medicare's postacute care benefits, the home health and skilled nursing services. Among the fastest growing benefits, Medicare spending for both home health and skilled nursing services has increased over 30 percent over the past several years. It is projected to grow at similar levels well into the future, and I am looking at a chart which clearly indicates that.

In the 104th Congress, this Subcommittee held several hearings on home health and skilled nursing care. The hearings sought to examine the causes for the tremendous growth in spending in these services, as well as to develop payment reforms that would maintain the quality of services while reducing their growth and discouraging fraud and abuse in these benefit areas.

In the last session, the Ways and Means Committee included in BBA, the Balanced Budget Act of 1995, new prospective payment systems for both home health and skilled nursing. Unfortunately, the President chose to veto the measure.

This year there is a consensus, I believe, among the Congress, the administration, and even the respective industries that home health and skilled nursing services should be purchased by Medicare using a prospective payment system.

Notwithstanding that, there are concerns that have been raised about the data and the methodologies available for prospective payment for these services. But despite these issues which have been raised, I am confident that now is the time to refine and implement the prospective approaches which have been raised.

To be sure, we do not have a complete solution, no initiative that we begin or conclude now is going to be perfect. But just as we learned in 1983, when the hospital prospective payment system was established that reform, although not flawless or perfect, nevertheless, can be effective in bringing about the desired effects.

I believe the longer we wait, we really do jeopardize losing a system which improves things for patients, providers, and Medicare.

I believe we can no longer wait for not just the perfect system, but even a better one. These costs are out of hand and they grow more out of hand every day. So, in that context, I look forward to the testimony that is going to be provided. Prior to recognizing the witnesses, if the gentlemen from Wisconsin wishes to be recognized for his own or someone else's opening statement, the Chair would do so.

Mr. KLECZKA. Not at this time, Mr. Chairman.

Chairman THOMAS. The panel before us is one that we have seen recently and we will see again, but it provides us with the kind of in-house expertise that is invaluable in our attempting to bring

forth a plan that Democrats and Republicans in the House and the Senate and the President can agree to.

We have with us Dr. Newhouse, who is Chairman of the Prospective Payment Assessment Commission. And I will recognize Dr. Young, who is with him, who has been the long-time Executive Director.

William Scanlon, who is the Director of the Health Financing and Systems Issues, of the General Accounting Office, and has with him Thomas Dowdal, who is the Senior Assistant Director of Health Financing and Systems Issues; and George Grob, who is the Deputy Inspector General in the Office of the Inspector General in the U.S. Department of Health and Human Services.

Obviously, any written testimony you have will be made a part of the record, and you can inform the Subcommittee in any way you see fit, beginning with Dr. Newhouse and moving to Mr. Grob and then to Dr. Scanlon.

I welcome the gentleman from California. We have finished our opening statements. The gentleman from Wisconsin was eloquent in presenting your opening statement. And we are moving now to the witnesses, if that is OK with you.

Dr. Newhouse.

STATEMENT OF JOSEPH P. NEWHOUSE, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION; ACCOMPANIED BY DONALD A. YOUNG, M.D, EXECUTIVE DIRECTOR

Mr. NEWHOUSE. Thank you very much, Mr. Chairman, for welcoming me and Dr. Young today. As you noted in your opening statement, payments for skilled nursing facilities and home health facilities have been growing very rapidly and they are now one-fifth of the part A spending, as my first chart shows.

As you also noted, there is a need to move away from the cost-based reimbursement policies that have been followed for these providers. And the Prospective Payment Assessment Commission endorses moves toward prospective payment and away from cost-based reimbursement.

On the skilled nursing facility side as my second chart shows, the bulk of the increase has been in payments per day which just in the last 4 years have gone from around $150 to just under $300 per day. That has mainly been driven by increased spending for ancillary services, although there has also been a substantial growth in new providers, as shown in chart 3.

Ideally, there would be a case mix system that could adjust for prospective payments but we do not have such a system in place. And in the meantime, we suggest that some kind of cost limits, either applied to ancillary services or to an all-inclusive per diem, be used.

Beyond that, we are concerned about some important more technical matters. In my testimony I note that facilities are not required to use any particular service unit definitions when billing. And, therefore, it is difficult to compare services across facilities. We recommend you mandate the use of a common procedure coding system, the HCPCS, across all facilities.

We also recommend that you have the SNF bill for all services. We are concerned if a prospective payment system were implemented, that some services could be shifted to part B. This is now very small but it could grow, and we think it would be easier on the beneficiary if all services were billed through the SNF.

Finally, we would eliminate the cost exemption for new providers. We think that exemption, which can apply for over 3 years, has encouraged the entry of new providers which was one of its intents, but that the change from around 10,000 SNFs to around 15,000 in the nineties, has meant that the policy has succeeded and we should declare victory.

Moving on to the home health side, home health has grown like skilled nursing facilities. From 1992 to 1996 it has grown from $7 to $17 billion. If you look at my chart 4, you see the payment growth annually has been around 25 percent a year. Visits growth has been around 22 percent a year. So, you put those two together and essentially all of the growth is in the number of visits, it is not in payment per visit.

If you look at chart 6, you see the home health visits per user divide into two rather distinct populations. Over one-half of the users use fewer than 30 visits, but that is a relatively small portion of the visits. In fact, it is right around 10 percent of the visits. So, over one-half the users are using only 10 percent of the visits.

At the other end of the spectrum, 12 percent of the users are using 150 or more visits and that accounts for one-half the visits. Since this benefit does not require a prior hospital stay, we believe that the high volume of users who are using relatively few visits are mostly the people coming out of a hospital, and the people using a lot of visits are people that are using chronic kinds of care.

There are some recommendations here, as well. We would try to limit the number of visits that Medicare would pay a full rate for. We would reduce that rate after a certain number of visits in the interim until we could get a prospective payment system up.

I have some technical comments here, as well, and also some comments on copays, but I see since the yellow light is on, I would like to skip to my last recommendation, which is contained in my last chart, where we show the hospital length of stay. We suggest that hospitals have been increasingly delivering services in a postacute setting that were delivered before in the hospital and included in the DRG payment, and that the implications of that is that we should attempt a demonstration project that would link the postacute payment with the acute payment. There are a number of technical issues to be resolved in that, but this would then not mean that the hospital would collect more money if it could figure out a way to deliver services in the postacute setting that had been delivered in the acute setting.

Thank you, Mr. Chairman, I will look forward to your questions.

[The prepared statement follows:]

Statement of Joseph P. Newhouse, Ph.D., Chairman, Prospective Payment Assessment Commission

Good afternoon, Mr. Chairman. I am Joseph Newhouse, Ph.D., Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied by Donald Young, M.D., the Commission's Executive Director. We are pleased to be here to discuss Medicare's policies for post-acute care providers, focusing on skilled nurs-

ing facilities (SNFs) and home health agencies. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

As we have testified previously before this Subcommittee, Medicare payments to post-acute care providers, which include skilled nursing facilities, home health agencies, rehabilitation facilities, and long-term care hospitals, are among the fastest growing components of the Medicare program. As a result of spending growth that has been nearly triple that of the rest of the program, the share of Part A spending accounted for by these providers has increased from 8 percent in 1988 to 25 percent in 1994 (see Chart 1).

Chart 1. Distribution of Total Medicare Part A Program and Beneficiary Payments for Selected Services, Fiscal Years 1988-1994

Year	Share of Part A Payments (In Percent)					Total Part A Payments (In Billions)
	PPS Hospital	Skilled Nursing	Home Health	Rehabilitation	Long-Term Care	
1988	89.2%	2.2%	3.6%	2.0%	0.3%	$ 59.1
1989	85.3	5.5	4.0	2.1	0.3	65.3
1990	84.4	4.8	4.7	2.6	0.3	72.3
1991	81.4	4.8	6.9	2.9	0.3	81.4
1992	77.4	6.3	8.6	3.4	0.3	92.0
1993	73.9	7.7	10.0	3.6	0.5	102.9
1994	71.1	8.8	11.7	3.4	0.7	114.1

Note: Percentages do not add to 100 because shares for hospices, cancer hospitals, children's hospitals, and psychiatric facilities are not shown.

SOURCE: ProPAC analysis using Medicare Cost Reports and other data from the Health Care Financing Administration.

Spending for services provided by SNFs and home health agencies make up the bulk of post-acute care payments. Between fiscal years 1992 and 1996, Part A payments to these two provider types nearly tripled, from $11 billion to $29 billion. While their spending growth has slowed somewhat in the past two years, the Congressional Budget Office projects that payments to SNFs and home health agencies will continue to rise faster than overall Medicare spending between now and 2002.

The rise in post-acute care spending is driven primarily by increases in both the number of beneficiaries receiving post-acute care and the number of services they receive. The increased usage reflects several factors. Medical advances and changing practice patterns have expanded the range of patients and the conditions that can be treated in post-acute care settings. This, in turn, has allowed post-acute care providers to furnish services that previously could be furnished only in acute-care hospitals.

Relatively generous payment and coverage policies also have contributed to growing post-acute care use. Post-acute care providers generally are paid based on their costs per unit of service. As you know, cost-based payment systems have few incentives for providers to improve efficiencies, and fee-for-service methods lead to greater utilization because provider revenues rise with each service furnished. In addition, Medicare's coverage guidelines permit broad discretion in determining the need for these services.

In our Report and Recommendations to the Congress, which we released yesterday, ProPAC makes a number of recommendations that, if adopted, would improve Medicare's payment policies for post-acute care providers and control spending increases. This afternoon, I would like to focus on our recommendations related to SNF and home health services. At some later date, we would be happy to discuss with you our views concerning payment policies for rehabilitation facilities and long-term care hospitals.

Much attention has been focused on developing prospective payment systems for SNFs and home health agencies. Both the Congress and the President have proposed such systems. The Commission strongly supports prospective payment systems for these, and all, providers. As I will discuss, however, SNF and home health prospective payment systems are not ready to be implemented. The Commission, therefore, recommends other improvements that can be implemented in the near term that will help constrain spending and move towards new payment systems.

After I discuss these recommendations, I would like to briefly address the relationships between acute care hospitals, hospital-based post-acute facilities, and the provision of post-acute care. Financial incentives and changes in service delivery are blurring the distinctions between the levels of care furnished by traditional acute

care hospitals and post-acute care providers. The Commission believes Medicare should begin considering payment policies that encourage the efficient delivery of services throughout a patient's entire episode of care.

Skilled Nursing Facilities

Medicare pays for up to 100 days of SNF care per spell of illness for beneficiaries who recently completed a minimum three-day hospital stay and are in need of skilled nursing or rehabilitative services on a daily basis. A beneficiary copayment equal to one-eighth of the hospital inpatient deductible begins on the 21st day of the stay; in 1997, this copayment is $95 per day. Services may be furnished by free-standing or hospital-based facilities. Certain rural acute care hospitals also may designate certain beds, known as "swing beds," to be used for skilled nursing care.

Although the Medicare SNF benefit covers up to 100 days of care, a typical Medicare-covered stay is much shorter. In 1994, for example, the average stay lasted 28 days. This varied substantially, however, depending upon whether the SNF was based in a hospital or was free-standing. The average stay in free-standing SNFs was 34 days, which was about twice the length of the typical stay in hospital-based facilities, and almost three times as long as in swing-bed hospitals. Interestingly, in a recent analysis we found that Medicare beneficiaries who also were Medicaid recipients accounted for a quarter of all SNF stays, but represented 40 percent of all 100-day stays. This may be due to the fact that these beneficiaries are more likely to remain in the nursing facility for custodial care. Since Medicare generally is a more generous payer than Medicaid, there are incentives for facilities to bill Medicare for the full 100 days allowed before billing Medicaid.

Medicare pays SNFs based on their costs. Separate payments are made for routine services, ancillary services, and capital. Payments for routine services, which include room, board, and skilled nursing services, are based on facility-specific costs subject to a limit. SNFs generally are reimbursed their reasonable costs without limits for capital and ancillary services. Ancillary services typically include physical, occupational, and speech therapies, as well as laboratory and radiology services.

Medicare payments to SNFs increased, on average, 28.8 percent per year from 1992 to 1996 (see Chart 2). The primary reason for this growth was the rise in Medicare's average payment per day, which jumped from $152 to $286 over this period. This per day payment growth is driven largely by increased spending for ancillary services, although the growth in new providers also has played a role. The number of beneficiaries receiving SNF services has further contributed to overall spending growth.

Mr. Chairman, like the Congress and the President, the Commission believes that reforming SNF payments is critical to constraining spending. In our March report, we make several recommendations that we believe would improve SNF payment methods. I would like to summarize our views.

Prospective Payment

The Commission believes that a prospective payment system could slow expenditures and encourage providers to deliver services in the most efficient manner. A critical component of any prospective payment system is the case-mix classification system. Such a system accounts for variations in patients' needs. Payments should be higher for patients with greater resource needs and lower for those who require less care. The ability to adjust prospective payment rates for differences in case mix is critical to ensuring fair payment to providers and access to services for patients. Without an adequate case-mix adjustment, prospective payment could unduly reward providers that treat low-cost individuals and penalize those that treat patients with more complex needs.

Developing a case-mix system is a challenging task generally, but it is especially difficult in the post-acute care arena where patients' service needs often depend on multiple factors. For example, functional status often is more important than diagnosis in predicting resource requirements for SNF patients.

Chart 2. Medicare Part A Skilled Nursing Facility Payments and Use, Fiscal Years 1992-1996

Year	Payments (In Billions)	People Served (In Thousands)	Days (In Millions)	Payments Per Day
1992	$ 4.2	757	27.5	$152
1993	6.0	878	33.2	181
1994	7.9	1,028	36.5	217
1995*	10.0	1,100	38.6	259
1996*	11.5	1,135	40.0	286
Average Annual Increase	28.8%	10.7%	9.8%	17.3%

Note: Payments are incurred Part A expenditures, rather than outlays, and do not include beneficiary copayments. Average annual increases may not match year values due to rounding.

* Estimated.

SOURCE: Health Care Financing Administration, Office of the Actuary.

The case-mix system being examined for use in a SNF prospective payment system is known as the resource utilization group system, version III (RUGS–III). This system uses patients' clinical characteristics, functional status, and counts of services received to classify patients. RUGS–III accounts for differences in resource use for each day of SNF care, rather than for the entire stay. Thus, a payment system based on RUGS–III would provide financial incentives for SNFs to control the cost of services provided during a day of care, but it also would continue incentives to increase revenues by lengthening patients' stays.

Ideally, a case-mix system should account for differences among patients over an entire admission to encourage facilities to manage the amount of care they provide throughout an entire stay, but such a system has yet to be developed for SNFs. An all-inclusive per diem approach to SNF payments, however, would be an improvement over current methods.

Limiting Ancillary Service Payments

Until prospective payment rates are implemented, the Commission believes that overall SNF expenditures should be constrained by limiting payments for ancillary services. As I mentioned, the growth in ancillary services is one of the major reasons SNF payments per day grew from $152 in 1992 to $286 in 1996.

For most ancillary services, providers are paid their costs subject only to Medicare's definition of reasonableness, which is very broad. In addition, Medicare policies allow SNFs to apply for an exception from their routine cost limits if they demonstrate high ancillary service use. This policy further encourages the provision of ancillary services.

Part of the difficulty in monitoring and controlling ancillary service use is that these services can be furnished and billed for in a number of ways. For example, if the services are provided by the SNF that admitted the patient, they are reflected on the SNF's cost report and the SNF is reimbursed its costs under Medicare part A. The admitting SNF may also have an external provider furnish ancillary services. If the external provider furnishes these services "under arrangement," the admitting SNF is reimbursed the costs it pays the external provider, and reports the services on its cost report. If the external provider is not "under arrangement" with the admitting SNF, the external provider bills Medicare directly for the ancillary services under Part B. Under this method, the services are not reflected on the admitting SNF's cost report, and the beneficiary is responsible for the applicable Part B cost-sharing requirements.

There are several ways to constrain ancillary payments. HCFA is developing salary guidelines that will place limits on the costs for which SNFs can be reimbursed when ancillary services are furnished under arrangement by an external provider. But these caps will not control service volume, nor will they affect services delivered by the admitting SNF or by external providers that bill Medicare directly. Other

methods that should be explored include applying cost limits to all ancillary services or developing prospective rates. These rates could be based on national or regional costs, or the resource-based relative value scale used for Medicare physician payment.

At the same time, the Commission recommends that uniform service codes be developed and mandated for reporting ancillary services. Currently, facilities are not required to use any particular service unit definitions when billing for ancillary services. Consequently, service use cannot be consistently quantified or compared across facilities. This prevents an accurate depiction of service costs, which is necessary to develop appropriate prospective rates. Implementing procedure codes like those used in the HCFA Common Procedure Coding System (HCPCS), which is used to define physician and independent therapy services, is a straightforward solution to this problem.

Consolidated Billing for SNF Services

We also recommend that the admitting SNF bill for all services, both routine and ancillary, provided during a patient's stay. Currently, the dollar amount of services provided to Part A-eligible beneficiaries but billed under Part B is quite small, but we are concerned that it will grow if Part A payments to SNFs are constrained. Consolidated billing would allow Medicare to monitor the total costs of providing SNF services, which is necessary to develop a prospective payment system. This requirement also would prevent efforts to shift the provision of services to Part B if a prospective system is implemented. Finally, billing Part A for all services would ensure that cost sharing requirements are applied consistently across beneficiaries.

Eliminating the Cost Limit Exemption for New SNF Providers

Finally, Mr. Chairman, the Commission believes that the initial exemption period for new SNFs should be eliminated. As I mentioned earlier, SNF payments for routine services are subject to facility-specific limits. Under current policy, however, new providers are exempt from these limits for up to their first four years of operation. During this period, they receive full cost reimbursement for all the services they provide, subject only to meeting Medicare's definition of reasonableness.

The new provider exemption has contributed to rising expenditures and helped to fuel rapid growth in the number of these facilities. Between 1990 and 1996, the number of SNFs increased by almost 50 percent, from 10,508 facilities to 15,553 (see Chart 3). While the majority of skilled nursing facilities are free-standing, the number of hospital-based facilities grew the fastest over this period.

The Commission believes that payments to new facilities should be subject to the national cost limits that apply to existing SNFs. For providers currently operating under an exemption, cost limits could be imposed immediately or phased in over time. Alternatively, the exemption could be eliminated for providers opening after a specified date.

Chart 3. Medicare-Certified Skilled Nursing Facilities, 1990-1996

Facility Type	1990	1992	1994	1996	Percent Change 1990-1996
Total	10,508	12,174	13,878	15,553	48%
Freestanding	8,120	9,502	10,818	12,086	49
Hospital-based	1,145	1,352	1,718	2,084	82
Swing bed hospitals	1,243	1,320	1,342	1,383	11

Note: Data are as of December each year.

SOURCE: Health Care Financing Administration, Office of Survey and Certification.

Home Health Agencies

The home health benefit presents a unique set of challenges for policymakers. Its broad coverage guidelines establish few constraints on utilization. Unlike SNF stays, qualifying for home health services does not require a prior hospitalization. In fact, the bulk of home health visits are not associated with a hospitalization.

While 60 percent of home health episodes—defined as a group of visits preceded and followed by a 60 day period without visits—were preceded by a hospital stay, 85 percent of home health visits in a given month did not follow a hospital stay within 30 days of the visit and about 50 percent of visits did not have a hospitalization within the previous year.

Medicare pays for home health services provided to beneficiaries if they are homebound and under the care of a physician who prescribes intermittent skilled nursing services, or physical or speech therapy. Once authorized, beneficiaries may receive an unlimited number of these services, as well as home health aide, occupational therapy, or medical social services. Beneficiaries pay no coinsurance or deductibles for home health visits.

Home health agencies are either facility-based or independent free-standing organizations. Medicare pays agencies the lower of their costs or a limit; there are no exemptions for new entrants. The limits are based on 112 percent of the average costs per visit for free-standing agencies for each of the six visit types, computed separately for urban and rural areas. Medicare does not specify the duration of a visit; therefore, the limits reflect varying visit lengths across and within individual agencies.

Payments for home health care more than doubled between 1992 and 1995 (see Chart 4). The primary reason for this spending growth is the number of visits provided. Medicare's home health cost limits have generally controlled payments per visit, but not the rise in the number of visits. The initial surge in utilization came after Medicare relaxed the home health benefit qualification criteria in the late 1980s in response to a legal challenge. Since then, the number of visits has continued to climb. Between 1992 and 1996, Medicare-covered home health visits more than doubled, from 127 million to 281 million. This is due both to more users of services and to more visits per user. Over this period, the number of annual visits per user increased by nearly 50 percent, from 52 to 76.

Chart 4. Medicare Part A Home Health Care Payments and Use, Fiscal Years 1992-1996

Year	Payments (In Billions)	People Served (In Millions)	Visits (In Millions)	Visits Per User	Payments Per User
1992	$ 7.3	2.4	127	52	$2,958
1993	9.6	2.8	160	57	3,464
1994	12.6	3.1	207	67	4,053
1995*	15.7	3.5	258	74	4,512
1996*	17.5	3.7	281	76	4,722
Average Annual Increase	24.6%	10.9%	22.1%	10.0%	12.4%

Note: Payments are incurred Part A expenditures, rather than outlays. Average annual increases may not match year values due to rounding.

* Estimated.

SOURCE: Health Care Financing Administration, Office of the Actuary.

The growth in the number of home health agencies also has contributed to spending growth. Between 1990 and 1996, the number of agencies grew by 71 percent to reach 9,886 (see Chart 5). The supply of free-standing and hospital-based facilities rose at about the same rate.

Beneficiaries' use of home health care reveals two distinct patterns. ProPAC analyzed fiscal year 1994 data and found that half of beneficiaries who received home health care received fewer than 30 visits. These visits were generally provided over a short period, and the majority of them were for skilled nursing services. By contrast, 12 percent of home health users had 150 or more visits. These users tended to receive home health care over long periods of time, sometimes a year or more, and received more home health aide visits, which include personal care services such as bathing, dressing, and simple wound dressings.

This small group of beneficiaries receiving large numbers of visits account for the bulk of home health use. In 1994, they accounted for slightly more than half of all visits (see Chart 6). These individuals are likely to be older or disabled. One of our recommendations is that the Secretary analyze the factors associated with this long-term use and determine whether additional policies are necessary.

The Commission believes a number of changes should be made to improve the home health benefit. I would like to discuss each of these in turn.

Defining the Home Health Care Benefit

One of the difficulties in constraining home health spending is the existence of broad coverage guidelines that allow for prolonged service use by an increasing number of beneficiaries. Beneficiaries qualify for home health services if they are homebound and under the care of a physician who prescribes intermittent skilled nursing care or physical or speech therapy. The homebound requirement is not very restrictive and is difficult to enforce. The physician certification requirement is a weak restraint at best, partly because there are no specific criteria to constrain physicians' determinations of medical necessity.

Chart 5. Medicare-Certified Home Health Agencies, 1990-1996

Agency Type	1990	1992	1994	1996	Percent Change 1990-1996
Total	5,793	6,419	8,057	9,886	71%
Freestanding	4,135	4,526	5,720	7,104	72
Hospital-based	1,658	1,893	2,337	2,782	68

Note: Data are as of December each year.

SOURCE: Health Care Financing Administration, Office of Survey and Certification.

Chart 6. Home Health Visits Per User, Fiscal Year 1994

Number of Visits Per User	Percent of Total				Average Number of Visits Per User
	Users	Visits	Skilled Nursing Visits	Home Health Aide Visits	
1-9	23.0%	1.8%	3.2%	0.3%	5
10-29	30.2	8.5	13.1	2.7	18
30-49	13.4	8.1	10.9	4.4	38
50-99	14.5	16.0	18.8	11.9	70
100-149	6.6	12.6	12.2	12.8	122
150+	12.3	53.1	41.7	67.9	275
Total	100.0	100.0	100.0	100.0	64

SOURCE: ProPAC analysis of a 20 percent sample of home health claims data from the Health Care Financing Administration.

Currently, the Medicare program is paying for what appears to be two different types of benefits. One covers care that is of short duration and is heavily weighted to skilled services. The other covers longer-term care and is weighted towards home health aide services.

The Commission believes that the Medicare program has a responsibility to ensure that the services it pays for are reasonable, necessary, and medically appropriate. The lack of a clearly defined benefit compromises this responsibility. Efforts to more clearly define the appropriate use of home health services could help constrain home health spending while allowing the Medicare program to continue to meet the needs of its beneficiaries.

Prospective Payment

To be effective, prospective payment for home health care must cover more than an individual visit. Ideally, the program should pay for all services furnished over a period of time. Defining the appropriate period is difficult, however, because in the home setting it is hard to identify when appropriate treatment begin and ends. In turn, this is complicated because of the lack of a clear definition of the home health benefit, or of the nature of the home health visit.

In addition, developing a case mix classification system is particularly challenging for home health. Part of the difficulty in matching resource use with patient needs stems from the wide variation in use patterns. This variation may, in some cases, be related more to a need for social support rather than to functional or to health status.

We understand that HCFA is in the preliminary stages of developing a new case mix system. This system, however, will not be ready for several years. In the meantime, the Commission believes that an interim system should be implemented immediately to stem rising expenditure growth. I would like to discuss some of our views on such a system.

An Interim Payment System

An interim payment system should specify per visit payments and limit total home health payments for each beneficiary. For the short term, per visit payments could continue to be based on the current method of agency-specific costs subject to a per visit limit. This method can effectively constrain per visit payments, although it continues the link between costs and payments, contrary to the premise of prospective payment. Alternatively, establishing prospective per visit payment rates could begin the transition away from cost-based payments. Separate rates for each home health service could be calculated using agency-specific costs, national average amounts, or a blend of the two. Either method would reward facilities for keeping their costs per visit below the payment amount.

As I mentioned earlier, however, a home health visit is not uniformly defined. Therefore, agencies could simultaneously reduce their costs and increase revenues by shortening visits and providing more of them. I should note that we recommend that Medicare require consistent home health visit coding so that home health usage can be monitored and evaluated. These data also are necessary to develop an effective case-mix adjustment system.

Beneficiary payment limits would dampen the incentive to provide more visits because such limits would encourage home health agencies to control the number of visits and adjust the mix of services furnished to each user. The limits could be associated with payments for services provided over a specific period, such as a year or a month. An annual limit would constrain service use for those beneficiaries who use services for a long period of time. Given that most visits are associated with these users, this might be an appropriate course of action. Shorter time periods would affect service use for almost all Medicare patients, although agencies could respond by spreading visits over a longer period to reduce the likelihood that payments for a beneficiary would reach the limit in the given time frame.

Beneficiary limits could be calculated based on agency-specific costs, national average expenditures, or a blended amount. The limits could be applied to an agency's aggregate payments or to spending for individual patients. Regardless of the method chosen, an outlier payment mechanism similar to that included under Medicare's Prospective Payment System for acute care hospitals could be incorporated to minimize incentives to avoid high-cost cases. That is, reaching a limit would result in a reduced per visit payments but the drop would not be to zero.

Home Health Copayments

Mr. Chairman, with the exception of lab services, home health is the only Medicare benefit not subject to beneficiary cost-sharing. The Commission believes it is

both appropriate and fair to impose modest copayments, subject to annual limits, for home health care visits.

With copayments, patients would share financial responsibility for services with the program. Although many beneficiaries have some form of supplemental insurance or Medicaid coverage that could cover these outlays, copayments could curb use by involving beneficiaries more in treatment decisions and making them more aware of service costs. Copayments also might limit fraudulent billing practices, since beneficiaries could identify services for which Medicare was billed but that were never delivered.

Bundling Acute and Post-Acute Payments

The Commission believes its recommendations on payment policies for post-acute care providers will slow spending growth and promote more equitable payments. Increasingly, however, the distinction between the levels of care furnished by traditional acute care hospitals and post-acute care providers is blurring. Consequently, controlling overall expenditures while ensuring quality care may depend on payment methods that encompass both the acute and post-acute portions of a patient's care.

Recent accelerations in declines in hospital lengths of stay combined with increasing post-acute care use suggests that hospitals may be moving services they previously furnished as part of the acute care stay to post-acute care sites. Lengths of stay declined when Medicare initially implemented the prospective payment system for acute care hospitals in 1984, but the greatest drops in lengths of stay have occurred in the 1990s (see Chart 7). Between 1990 and 1995, length of stay for all Medicare cases fell 20 percent. Acute care hospital stays for DRGs associated with frequent post-acute use declined even more rapidly, on average.

Chart 7. Average Medicare Hospital Length of Stay, Fiscal Years 1984-1995

Fiscal Year	Length of Stay
1984	8.8
1985	8.4
1986	8.2
1987	8.3
1988	8.4
1989	8.3
1990	8.4
1991	8.2
1992	8.1
1993	7.9
1994	7.6
1995	7.1

SOURCE: MedPAR summary statistics

Increasingly, acute care hospitals are entering the post-acute care arena by developing their own post-acute care capacity. Between 1990 and 1996, the number of hospital-based skilled nursing facilities and home health agencies increased by more than 60 percent. In 1996, about 40 percent of hospitals operated skilled nursing facilities and half owned home health agencies.

Offering hospital-based post-acute care services provides financial advantages to hospitals because of the separate payment systems used to reimburse these services. Moving patients into post-acute units allows hospitals to lower their inpatient costs relative to their DRG payment, as well as receive cost-based reimbursement for services provided in the unit.

Hospitals appear to be responding to these financial incentives. A recent ProPAC analysis showed that hospitals with skilled nursing units were more likely to discharge patients to a SNF than those without a SNF, although we did not see a similar pattern for hospitals with hospital-based home health agencies.

Our analysis also showed that hospitals that have their own post-acute care providers have shorter acute care lengths of stay than hospitals without such providers. Furthermore, patients spend less time in hospital-based SNFs than in free-standing facilities: 17 days compared to 34 days. It is not clear why the length of a SNF stay varies so widely between these settings. ProPAC analyses indicate that the DRG assigned to each patient during the hospitalization that preceded the SNF stay was similar across facilities. Possibly, the differences are related to patient severity of illness and differences in functional abilities. Our analyses show that free-standing facilities tend to admit a greater share of patients who are 85 and older. These patients may have more functional limitations, requiring longer SNF stays. Unfortunately, current data on patient severity and functional need are not adequate to make accurate distinctions between the types of patients treated in these different settings. Longer stays in free-standing facilities may also be related to an increased number of dual-eligible beneficiaries who receive up to 100 days of Medicare-covered care and then move on to Medicaid custodial care.

While additional data are needed to better understand the reasons for differing patterns of service delivery across hospitals and post-acute care providers, this information demonstrates that Medicare's current provider-specific payment polices are lagging behind the changing patterns of acute care hospital and post-acute care service use. The disparate payment systems used to reimburse providers for these services do not encourage them to minimize their total costs of care over an episode of illness by directing patients to the least intensive appropriate site of care, or to coordinate services across settings. At the moment, a hospital gains revenues by moving a patient to the post-acute provider for the last few days of the acute stay. The Commission believes consideration should be given to bundling payments for the acute and post-acute portions of an episode of care. Bundling would provide incentives to control total episode costs. A demonstration project would provide insight into whether such a method could constrain spending and better coordinate service delivery.

A bundled system has the potential to affect a substantial share of Medicare outlays. In 1994, about one quarter of all Medicare patients discharged from an acute care hospital received services from a post-acute care provider within 30 days, and more than 10 percent of these individuals received services from more than one of these providers. For certain DRGs, up to 80 percent of discharges went on to receive post-acute care.

A demonstration project could focus on the small group of DRGs that accounts for the largest share of post-acute care. A number of technical issues would need to be addressed, including deciding which entity would receive the episode payment. Depending on the results of the demonstration, a bundled system could benefit beneficiaries because overall service use would be better coordinated. It also could benefit the Medicare program by controlling service utilization, which would lead to lower expenditures.

Conclusion

Mr. Chairman, payments for post-acute care services, particularly for skilled nursing facilities and home health agencies, are growing at an unsustainable rate. Reforming the payment methods for these providers should be given a high priority. ProPAC is continuing work in this area and we will share our findings with the Subcommittee as you seek ways to improve post-acute payments.

This concludes my formal statement, Mr. Chairman. I would be pleased to answer any questions from you or other members of the Subcommittee.

Chairman Thomas. I thank you, Dr. Newhouse.

Mr. Grob.

STATEMENT OF GEORGE F. GROB, DEPUTY INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Grob. Thank you, Mr. Chairman.

The testimony which was provided for the record replays the same story that everyone else is saying these days. It remarks on

the very fast rate of growth of the home health benefit, both in terms of the money being spent and the number of visits, and similar problems in the skilled nursing facilities setting.

So, I would like to use my 5 minutes here instead to highlight just a few facets of the problem which do not always receive precise attention but which we think are helpful to understand what is going on behind those numbers.

The first one, of course, for people in my line of work is a concern over fraud and abuse. This is something we have been looking at in the home health setting, and I would like to direct my initial remarks to home health. I will turn to SNFs later.

I must tell you, Mr. Chairman, we have been finding lately that there seems to be a rise or an increase in the amount of things we might call fraud and abuse in the home health setting.

We have recently completed eight audits of providers in three States, Florida, Pennsylvania, and California. And in those audits we found error rates for the services delivered to range from 19 to 64 percent. The errors we found were related to patients not being home-bound, services not rendered or documented, services not medically necessary, and invalid physician certifications of these services.

Now, these audits were performed of providers for whom we had some concern or some reason to believe that they might be having more problems than other providers are. So, we have undertaken additional work as well where we have taken random samples—for example, one study now where we are looking at Texas, New York, Illinois, and California, and another study where we have a random sample nationwide of these services. In this context, although these studies are not finished yet, I can tell you that the preliminary work we are seeing in these studies now shows us error rates that are comparable to the rates we were finding in the preliminary work of the studies we have already published. So, I do think we need to be concerned about that.

Mr. STARK. Mr. Grob, you are not finding any under payments in those areas, are you?

Mr. GROB. No, sir.

Mr. STARK. OK.

Mr. GROB. Another point that is frequently mentioned in this context has to do with the variation in payments that has been mentioned before. We, too, have done our studies of this and can repeat numbers very similar to those that we heard from the previous speaker about some providers providing 30 visits, others providing into the hundreds of visits.

When we did our study, I would like to let you know that we tried to find out what could account for this and used statistical studies to see what might be underlying it. And I can tell you that we were able to rule out age, race, gender, deaths while in care, qualifying condition, and principal diagnostic codes. We were also able to rule out, as explanatory causes, deficiencies or complaints to the Health Care Financing Administration survey and certification staffs and accreditation status.

These statistics are very rough measures of perhaps what the medical need of the patient is or the quality of care that is rendered. We know they are not perfect. It was the best we could get

our hands on. But it seems to indicate that the variation is not related to the medical needs of the patients. Rather it seems to be much more related to the discretion that the home health agencies have in promoting a larger number of visits.

We have continuously found problems with the role that the physician plays in certifying visits, physicians not understanding the requirements or not having valid physician certifications. When we interviewed physicians, too, we found they seemed to play a somewhat active role in the beginning when a patient first comes in, but in terms of the continuing monitoring of care, their role becomes much, much weaker.

The one concern we have for the prospective payment system, which we do favor and we think it is a very good solution to the problem, is simply that we need to take action very quickly. Each year this program is growing by 25 or 30 percent. So, if it is delayed, we are going to lock in some increases in that program which will be difficult to undo with the passage of time.

So, we would urge that if it takes time to develop a prospective payment system, that other options of a structural nature be used temporarily and in the meantime. It might include such things as caps on visits per beneficiary, costs limits per beneficiary, visit limits based on the condition the person has, benefit targeting relating to the types of visits that might be provided to different beneficiaries, limits on the average number of visits per beneficiary per home health agency, limits on the average cost, and so forth, and possibly, as well, beneficiary copayments which are used in many other parts of the Medicare Program.

Let me shift my attention just momentarily to the problems in SNFs. And what I would like to focus on there is the remarks of our colleague here who was commenting on the need to make sure we consolidate all of the payments, as much as possible, into the payment made under the prospective payment system.

Right now, when we pay SNFs, we pay a per diem, we pay ancillary costs, capital costs, and there are services in part B as well. These programs all have different rules and providers tend to game the system, trying to seek where the reimbursement is the highest. I will give you only one example, although I have more.

We found nursing homes that billed for enteral nutrition under their per diem rate are probably charged about 30 percent less than Medicare pays under part B. And the nursing home pretty much has the ability to charge it either way or to arrange for a provider to do it. But the incentives for bulk purchasing and competitive bidding that you find in the nursing home setting seem to work. We found other examples of that as well.

So, our primary recommendation for the skilled nursing facility is to make sure that we specify all the items that are to be included in the prospective payments so that we do not end up paying for them outside the rate. And, then, of course, as was remarked, those that do not fit under the per diem rate or the prospective payment, to require that the nursing home be the one that submits those bills so they can be concerned about the care the patient gets.

Thank you very much.

[The prepared statement follows:]

Statement of George F. Grob, Deputy Inspector General for Evaluation and Inspections, Office of the Inspector General, U.S. Department of Health and Human Services

Good Morning, Mr. Chairman. I am George Grob, Deputy Inspector General for Evaluation and Inspections, Department of Health and Human Services. Since 1976, the primary mission of the Office of Inspector General has been to protect and recommend improvements to the programs and management of the Department of Health and Human Services. This mission is accomplished through audits, investigations, and inspections designed to reach all organizational levels of the Department, its contractors, grantees and providers of goods and services to departmental programs.

The press release for this hearing indicated a particular interest of this Subcommittee in prospective payment systems for Medicare home health and skilled nursing facility services. Our office has done a considerable amount of work related to these subjects over the last several years. I am pleased to have this opportunity to summarize the results of our audits, inspections, and investigations on these topics and hope this information will be useful to you in formulating legislation to deal with pervasive problems afflicting these program areas.

In summary, let me say that our work strongly supports the need for prospective payment or other similar approaches for home health and skilled nursing care. Such systems are needed to prevent significant fraud, waste, and abuse that has arisen in these programs and to control costs which are now almost uncontrollable. With regard to home health, I will emphasize the emergence of significant fraud and abuse, the immediacy of the need for action, and options to limit Medicare's exposure to losses while prospective payment systems are being developed. With regard to skilled nursing facilities, I will describe the complexities of the current payment systems and show how this provides incentives and opportunities to unbundle services and billings, with resulting cost increases for both the Medicare program and its beneficiaries and possibly loss of quality of care. I will then discuss some important details to be considered in the design of a prospective payment system for skilled nursing facilities.

Home Health

Medicare Part A pays for home health services for beneficiaries who are homebound, in need of care on an intermittent basis, and under the care of a physician who both establishes a plan of care and periodically reviews it. Beneficiaries receive numerous services including part-time or intermittent skilled nursing care; home health aide services; physical, speech and occupational therapy; medical equipment and supplies; and medical social services. The benefit is unlimited as long as the services are considered medically necessary.

Rapid Growth.

All observers of Medicare's home health program are quick to describe its rapid growth. It is the fastest growing component of the Medicare program. FY 1996 expenditures are estimated to have been $16.9 billion, or five times the $3.5 billion spent in 1990. The number of beneficiaries increased from 2 to 3.7 million during this same period. Home health expenditures now account for 8.8 percent of total Medicare spending, compared to 3.5 percent in 1990. Utilization continues to rise from an average of 36 visits per Medicare beneficiary receiving home health benefits in 1990 to 72 visits in 1995, and an additional increase to 76 in 1996. The Congressional Budget Office has estimated that spending for home health services will reach $31 billion by 2002.

The reasons for the rapid growth of home health expenditures are well known—demographic trends, court cases which have liberalized coverage of the benefit, technological advances, such as infusion therapies, which can now be provided at home, a growing and aging Medicare population, and a trend toward providing more care in the community instead of institutions. Growth can be attributed to the fundamental structure of the benefit as well as problems with the management of it.

Fraud and Abuse.

It is unfortunately true that fraud and abuse also play a significant role in the high growth rates of home health.

A synopsis of some of the investigative cases completed by the Office of Inspector General over the past two years illustrates the vulnerability of the Medicare program and the type of home health fraud and abuse it is exposed to.

- The Chief Executive Officer and his wife and co-owner at a Georgia home health agency were convicted of conspiracy to defraud Medicare. They were accused

of filing cost reports that included personal expenses, political contributions, ghost employees and lobbying expenses. They were also charged with mail fraud, paying kickbacks, making false statements, witness tampering, money laundering, and submitting false tax returns. The defendants were sentenced to 90 months and 32 months incarceration, respectively. These individuals and the company will pay $255 million fines, restitutions, and other penalties.

- The owner of a Louisiana home health agency was sentenced to 5 years probation and ordered to repay $119,000 for defrauding the Medicare program. The owner included in Medicare cost reports the expenses of a costume shop she owned and a magazine she produced monthly. Expenses charged included payroll, leases, telephone service, and advertising.
- The owner of a Texas Home health agency entered a settlement agreement to pay $493,000 in civil damages and penalties for submitting false Medicare claims. Investigation found that over a 9-month period, the agency billed Medicare for home health services for patients that were not homebound, and for services not rendered.

These are not isolated examples. We have now completed audits of eight home health agencies in Florida, Pennsylvania, and California. These audits revealed agency error rates—the percent of the home health visits paid for by Medicare but which did not meet Medicare guidelines—from 19 to 64 percent. We found visits that were not reasonable or necessary, patients who were not homebound, visits which were not documented or even provided to Medicare beneficiaries, and improper or missing physician authorizations. In a few cases we even found forged physician signatures. Preliminary data from Statewide audits underway in New York, Texas, Illinois, and California show similarly high error rates.

Unjustifiable Variation.

We have also found extreme variation in payments to home health agencies. In FY 1993, lower cost home health agencies (those which provided less than the national average of visits per episode) averaged 30 visits per episode, whereas the higher cost agencies (those with visits per episode above the national average) provided 85. One year later, the lower cost agencies provided 33 visits per episode, while the average for the higher cost agencies jumped to 102.

We tried to find out what could account for the variation in the number of visits.

Beneficiary characteristics and medical condition did not account for it. We specifically examined beneficiary age, race, gender, deaths while in care, qualifying conditions, and principal diagnostic codes. We found nothing here to suggest that beneficiaries in the high-cost groups were any sicker or in any greater need of medical services than those beneficiaries in the low and middle-cost groups.

We also found no differences in the quality of care provided by home health agencies, as measured by the number of deficiencies and complaints recorded by HCFA's Survey and Certification Branch and the home health agencies' accreditation status. Providers in the higher cost group had about the same number of deficiencies as did those in the lower groups.

We did find that private for-profit home health agencies tended to be the more costly. Additionally, we found that home health agencies in four southeastern States—Tennessee, Alabama, Mississippi, and Georgia—averaged twice as many visits per Medicare beneficiary as home health agencies in all other States. These four States averaged approximately 100 visits per episode compared to approximately 54 for all other States.

It appears to us that other than the geographic difference, the differences are due mostly to the discretion afforded home health agencies to influence the amount of care given to their clients.

Looking for Solutions.

Our work has shown repeatedly that there is a need for greater control and protection from fraud and abuse. However, we must proceed cautiously to ensure that any measures to control the benefit do not harm those beneficiaries who truly need these services. Our focus must be on protecting the benefit as well as controlling expenditures and minimizing the potential for fraud and abuse.

The logical places to establish controls are: 1) HCFA's Regional Home Health Intermediaries, first at the point of certifying providers to participate in the Medicare program, and later when reviewing bills submitted for payment; 2) physicians authorizing the plan of care; 3) the beneficiaries receiving the care; and 4) the service providers.

Unfortunately, the volume of new providers entering the market and the volume of claims to be processed have made it extremely difficult for HCFA's intermediaries to scrutinize provider applications and bills as much as is needed to prevent fraud, waste, and abuse. HCFA is now developing new conditions of participation which

may help prevent problem providers from entering the program; but the volume of claims will remain a problem for some time to come.

Physicians' involvement in home health care is inconsistent. Our studies have shown that they are typically involved in initial referrals of patients for home care, approving plans of care, and monitoring progress of complex patients. However, they are less involved in continuing monitoring of beneficiary eligibility, coordinating services, determining medical necessity of services, visiting patients at home, and participating in interdisciplinary conferences.

Likewise, Medicare beneficiaries have limited involvement in controlling home health services they receive. Many beneficiaries, while satisfied with the home health care they receive, do not understand what Medicare paid for. Furthermore, they have no financial liability or responsibility for the services. Therefore, beneficiaries have little incentive to control services.

Most home health service providers are dedicated to caring for their clients. They have not increased their visits just to maximize profits, but have focused on the needs to the beneficiaries under their care. Unfortunately, for unscrupulous providers, the current cost-based reimbursement systems does not provide incentives for providers to properly manage costs. In fact, it does just the opposite. Cost-based reimbursement provides incentives to increase revenues by providing more visits. Theoretically, home health agencies cannot themselves authorize home health visits. However, they can be very influential is obtaining certification from physicians.

To learn more about how costs can be controlled, we examined practices of private insurance companies, State Medicaid agencies, the Department of Veterans Affairs, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and numerous health maintenance organizations (HMOs). While their benefit structures were similar to Medicare's, they did try to control costs in ways that Medicare does not. For example, some place limits on the number of visits or caps on the dollar amount that can be paid. Many tried to target their programs more specifically to the individualized needs of their beneficiaries. They also undertook more intensive utilization control measures such as reviews of physician referral rates, postpay edits, and utilization profiling combined with physician education.

We found that HMO's provide home health care for only one-fourth the cost of the Medicare fee-for-service program. The HMOs that responded to our survey spent an average of $882 per beneficiary in 1994 compared to Medicare's fee-for-service cost of $3,464. They do this by using case managers to review and approve patient care. These case managers work with physicians to plan care and write orders, review and approve both initial and continuing visits, review medical necessity, track and report outcomes and cost savings on a monthly basis, and participate in quality assurance activities such as clinical record reviews, team meetings, and case conferences. They carefully control both the number and kind of visits, constantly evaluating the care provided.

Administrative Remedies.

HCFA has already begun to take administrative action to address problems which we have described here. As mentioned earlier, a new set of conditions of participation is under development. HCFA has also strengthened the role of its Survey and Certification teams by asking them to look for financial abuses during the surveys. HCFA has recently started issuing a Notification of Utilization (similar to the Explanation of Medical Benefits used for other Medicare bills) to inform patients of the services billed on their behalf, and in other ways is reaching out to educate both beneficiaries and physicians about their roles in preventing abusive billing.

Additional steps can also be taken. Based on private sector practices and on our own analysis of weaknesses which we found, we have made several recommendations aimed at controlling Medicare expenditures and reducing the potential for fraud, waste and abuse. These include:

- Focused HHA Reviews: Target the HHAs with average reimbursement higher than a standard established by HCFA for closer scrutiny by the Survey and Certification Branch as well as reviews by the Regional Home Health Intermediaries.
- Regional Home Health Intermediary Resources and Flexibility: Ensure that Regional Home Health Intermediaries have adequate resources and tools to review applications for providers wishing to participate in the Medicare program and to detect and act on claims they suspect are fraudulent or abusive.
- Case Management: Fund case management programs in the fiscal intermediaries. Case managers would be used to monitor and manage cases that reach a trigger point, or benefit threshold.
- Beneficiary Certification: Require beneficiaries to certify their "homebound" status.

• Stronger Physician Role: Require physicians to examine the patient before they order home health service. Require the patient to see the certifying physician at least once every 6 months.

Legislative Changes.

However, we believe that management actions like these will not be sufficient. The problems are so commonplace that a restructuring of Medicare's payment system is called for. Options include:

• Prospective Payment System: Establish a per episode prospective payment system. This may be the most effective long-term model for restructuring the benefit. We encourage HCFA to continue their work in testing such a system. We believe, however, that it is important that a new system not "grandfather" in utilization patterns of the higher-reimbursement agencies. It is worth noting that this was an important issue when a prospective payment system was being developed for hospitals.

• Cap on Number of Visits Per Beneficiary: Limit the number of visits that Medicare will pay for any one beneficiary per year, or per episode. This would be similar to the approach Medicare takes for skilled nursing facilities.

• Cost Limits Per Beneficiary: Develop a cost ceiling, limiting the amount payable in a given period for home health benefits on behalf of a beneficiary. The period to which the limit could apply might be lifetime, annual, or episodic. This is similar to a prospective payment system, except that it provides a cap rather than a fixed fee for services rendered. Also, the cap may or may not vary according to the diagnosis or treatment of the patient.

• Visit Parameters Based on Condition: Set parameters on the number of visits a beneficiary may receive for a specified condition. When that parameter is reached, an additional set of conditions, documentation, or justification would be required to obtain reimbursement for additional visits.

• Benefit Targeting: This is similar to the preceding option, but goes further by considering not only the number of visits authorized, but also the types of visits. Medicare might wish to channel patients with different needs (e.g., chronic vs. acute care patients) into different home health "programs," with different kinds of treatments, to create better, more appropriate care and greater program controls.

• Limit on Average Number of Visits Per Beneficiary for Each Home Health Agency: Develop an average number of visits per beneficiary which HHAs may provide in a year. Beneficiaries who need a large number of visits would be offset by those who need very few visits. This budget would need to be flexible enough to allow for hardship cases, which warrant an unusually high number of visits, and/or adjusted for case mix.

• Limit on Average Cost Per Beneficiary for Each Home Health Agency: This is the same as the preceding proposal, except that costs rather than visits would be used as the limiting factor.

• Beneficiary Copayments: Require beneficiary copayments as a way to give them a stake in home health billings and to further ensure that unnecessary services are not provided. A copayment could begin upon admission or after a certain number of visits. This would create an incentive for patients and families to reduce over utilization. Medicare uses co-payments or other forms of co-insurance for most of its benefits.

Given the current rapid growth rate, it is important to take action quickly. If the goal is to establish a prospective payment system, and if that cannot be done immediately, we suggest that one or more of the approaches outlined above be used in the interim.

Skilled Nursing Facilities

Medicare Part A provides up to 100 days of coverage for stays in a skilled nursing facility (SNF) that is certified as meeting a set of statutory requirements. Like home health, this is one of the fastest growing parts of the Medicare program. Medicare Part A payments to SNFs have more than doubled, from $3.7 billion to more than $9 billion from FY 1992 to FY 1995. The number of beneficiaries in covered SNFs stays increased from 779,000 in 1992 to more that 1 million in 1994.

Moving Toward Prospective Payment.

Because of this rapid growth, and because the current payment system does not provide adequate incentives for providers to restrain costs, both the Administration and Members of Congress have advocated switching to a prospective payment system.

In recent years, the Office of Inspector General has also been paying close attention to Medicare SNF payments as part of a broader look at nursing home care in

general—including medical services which are reimbursed under Medicare Part B for Medicare beneficiaries who are residents of nursing homes (whether or not the stay itself is paid under Medicare Part A).

Our audits and inspections reveal vulnerabilities inherent in Medicare reimbursement rules, and provide some insights which may be useful to consider by those developing a prospective payment system for SNFs. In summary, the studies show that composition of services and resources reimbursed under a prospective system are just as important as the rate of payment itself, and that if care is not taken to prevent the unbundling of services from the payment rate, then uncontrollable and wasteful cost growth will continue unabated outside the prospective payment.

Complications of the Current Payment System.

The following is a brief description of the way Medicare pays for nursing home services.

Part A.

Medicare Part A only pays for nursing home care in a skilled nursing facility. The amount it pays has three separate components—the per diem, ancillary costs, and capital costs.

Per Diem: The per diem, or routine service costs such as nursing, room and board, administrative and other overhead costs of the facility. These costs are subject to a limit.

Ancillary Services: Ancillary costs include laboratory, radiology, drugs, therapy, and other items and services. These are paid on the basis of reasonable costs, but are not subject to a limit as such.

Capital: Capital is also reimbursed on the basis of cost and is not subject to a limit as such.

A deeper look at the Part A payment methods will reveal additional details about how the per diem limit is established and how payments vary depending on whether A SNF is free standing or hospital based. Certain SNFs, under certain conditions, are also allowed to elect to be paid on the basis of a prospective payment rate.

Part B.

In addition to the Part A payment, Medicare beneficiaries who are residents of nursing homes, including but not limited to Medicare Part A covered SNFs, may be eligible to be reimbursed under Medicare Part B for medical services covered under that part and for which they would be eligible whether or not they are in a nursing home. A good example would be physician services. Other examples include psychotherapy, lab services, wound care, etc.

Some services can be reimbursed under more than one payment category. This provides opportunities and incentives for service providers to "game" the payment system to maximize reimbursements, and it reduces incentives to economize. It sometimes also dilates the responsibility for the overall care of a nursing home resident.

Medicare Not Always a Prudent Purchaser.

We found that in 1992 Medicare Part B paid about $57 million in total enteral nutrition; $55 million in rehabilitation therapy; and $44 million for surgical dressings, incontinence supplies, braces, catheters, and similar items. Beneficiaries paid up to $18 million in coinsurance and deductibles for these services. We believe that these services are more appropriately paid as part of the per diem under Part A of the program. One reason is that payment under Medicare Part B reduces the incentive for nursing homes to economize. Some recent studies provide evidence to this effect.

Enteral Nutrition: Some nursing homes include their enteral supplies in their per diem rate. We found that nursing homes and hospitals who purchase enteral nutrition supplies in bulk are able to get them on average 30% below what Medicare allows for them. We also looked at what other third party payers are able to purchase enteral products at rates 17 to 48 percent less than Medicare allows.

IV Poles: We found that IV poles can be purchased in bulk by nursing homes for as little as $33. Generally, the cost of these poles is included in the nursing home per diem rate, and Medicare benefits from the incentives that nursing homes have to keep their costs down and from the limit placed on per diem payments. However, current payment rules allow these poles to be reimbursed under Part B if they are used for enteral feeding services. The purchase costs on the Medicare fee schedule exceed $110.

Fraud and Abuse.

Another problem with Part B reimbursement for nursing home patients is their vulnerability to fraud and abuse. Over the years, we have observed many types of abusive practices that have occurred in SNF and other nursing home settings. These include outright fraud such as billing for services and supplies that have not been provided, upcoding, and unnecessary or uncovered services. In some cases we have observed aggressive marketing techniques including the offering of kickback and the routine waiver of coinsurance. Excessive utilization has also been problematic in this setting.

We have particular concern regarding Part B supplies and services when they are furnished in a nursing facility setting because they are frequently furnished and billed by an outside entity, not the nursing home. When items are furnished as such, the nursing home may have very little to do with authorizing or overseeing the service or the quantity of services provided. Without appropriate oversight, the opportunity and incentive exist for aggressive marketing as well as excessive and unnecessary utilization. While the following examples of our work are not limited to SNFs, they illustrate some of the abuses we have found in these settings:

Wound Care: We found that questionable payments of wound care supplies may account for as much as two-thirds of the $98 million in Medicare allowances from June 1994 through February 1995. In the more egregious cases:

- One beneficiary was charged $5,290 for tape over a 6-month period, almost $5,000 of which appears excessive. Medicare paid for, but the beneficiary probably did not receive, 66,000 feet or 12.5 miles of one-inch tape.
- Another beneficiary was charged with $11,880 in hydrogel wound filler, $11,533 of which may be unnecessary. This beneficiary's record showed payments for 120 units of one-ounce hydrogel wound filler each month for 6 consecutive months, or over 5 gallons.

We also assessed the marketing of wound care supplies and found that nursing homes and physicians generally determine which patients need supplies, but some suppliers determine the amount provided. Of most concern, we found that 13 percent of nursing homes have been offered inducements in exchange for allowing suppliers to provide wound care products to patients in their facility.

Incontinence Supplies: We found that questionable billing practices may account for almost half of incontinence allowances in 1993. In addition, information obtained from nursing facilities and beneficiaries indicates that some suppliers engage in questionable marketing practices.

Upper Body Jackets: We reported that 95 percent of claims paid by Medicare ($14 million in 1992) were for non-legitimate devices. These non-legitimate devices are more properly categorized as seat cushions rather than body jackets. In addition, we found that suppliers, rather than physicians, initiated orders for the non-legitimate body jackets, and that physicians provided limited controls for preventing the sale of non-legitimate devices.

Mental Health Services: We conducted a review of the medical necessity of mental health services furnished in nursing homes and found that in 32 percent of the records we reviewed that Medicare paid for unnecessary services ($17 million or 24 percent of all 1993 Medicare payments). In addition, we found that in 16 percent of the records we reviewed Medicare paid for highly questionable services ($10 million).

Overspending for Ancillary Services.

As noted earlier, ancillary services are not subject to the limit imposed on per diem. Also, since they are reimbursed under Part A, they are not subject to the limits imposed on services reimbursed under Part B. This can lead to excessive costs which are difficult to control.

For example, we recently completed 16 joint HCFA-directed surveys of Florida SNFs which were undertaken to evaluate the medical necessity of the care and services provided and the reasonableness of the charges and reimbursements made to these facilities. These 16 surveys of 1-year periods, questioned charges of about $2.5 million for selected beneficiaries residing in these facilities. Most of the questioned costs related to physical, occupational, and speech therapy services. We recommended that these overpayments be collected and that the fiscal intermediaries conduct a focused review of all rehabilitation therapies at most of these facilities.

We are now studying the cost of portable x-rays provided to nursing home patients. We believe that Medicare pays more under the Part A SNF benefit than it would if reimbursed under Part B.

Administrative Remedies.

I am pleased to report that in addition to discovering problems we are also developing new and effective ways to deal with them. One good example is the problem with incontinence supplies which I mentioned above. Our exposure of these billing abuses, coupled with a coordinated nationwide investigation involving more than 20 separate cases and a concerted effort by the Health Care Financing Administration's durable medical equipment carriers has turned the escalating reimbursements downward. By the end of FY 1995, the abusive practices we had identified had all but disappeared and Medicare is now saving more than $104 million per year as a result. In addition, approximately $45 million has been recovered through seizures and restitutions from abusive incontinence suppliers. This type of concerted effort can eliminate some of the other abuses I have discussed in my testimony.

Legislative Amendments.

Unfortunately, administrative action is not sufficient to address all the vulnerabilities associated with skilled nursing facilities. It is important to get at the underlying systems which leave Medicare so vulnerable to abuse. Therefore, we believe it is necessary restructure the way Medicare pays for these services.

A prospective payment system is a good approach to control costs for skilled nursing care. As the above examples show, however, it is important to simplify the categories of payment in order to prevent excessive costs as a result of unbundling services from the nursing home payment or avoiding payment limits that currently apply to the routine per diem expenses and Part B services.

We therefore recommend that any proposal for a prospective payment system capture as many of the services as possible into the prospective payment rate. Those for which this would be inappropriate should be consolidated into a single bill to be submitted by the nursing home. Other approaches are to pay no more for nursing home services than a prudent nursing home would pay through competitive bidding or bulk purchasing arrangement; or to make capitation payments to nursing homes for services provided to residents. Each of these strategies attempts to take advantage of the ability of nursing facilities to more economically provide services and supplies to their patients with the cost savings passed on to Medicare. Additionally, these payment mechanisms recognize the importance of the nursing facility in overseeing the quality of their residents' care. Since nursing facilities are significantly involved in the planning and provision of patient care, they arguably are the most appropriate entity to scrutinize providers and determine the most cost effective methods of obtaining and utilizing the services and supplies needed to meet the medical needs of their patients.

CONCLUSION

I appreciate the opportunity to appear before you today and share with you some of our work and recommendations related to prospective payment systems for Medicare home health and skilled nursing facility services. I would be happy to make any of our reports available to the Subcommittee and to also respond to any questions you may have.

Chairman THOMAS. Thank you, Mr. Grob.
Dr. Scanlon.

STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY THOMAS DOWDAL, SENIOR ASSISTANT DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES

Dr. SCANLON. Thank you very much, Mr. Chairman and Members of the Subcommittee. My colleague, Mr. Dowdal, and I are very happy to be here today as you discuss Medicare's skilled nursing facility and home health care benefits and the administration's proposals to reform each of them.

As has been noted, after modest growth in the eighties, Medicare's expenditures for these two services has skyrocketed, reaching double-digit levels every year since 1990.

As the chart to my right indicates, for home health in a very dramatic way, there has been a number of legislative and programmatic changes over the years that directly or indirectly affected this benefit. And a similar graphic could be displayed for the skilled nursing facilities.

Despite all these changes, there were two that made the most difference. The reissuance of a coverage guidelines for SNFs in 1988 and for home health care in 1989 were the triggers that led to explosive growth.

It is also important that the causes of growth in these two benefits are different, and this is something that we need to keep in mind as we consider reforms.

In the case of SNFs, Medicare payments have grown primarily because a larger portion of beneficiaries used this benefit and because a large increase in the provision of ancillary services occurred. For home health care, both the number of beneficiaries and the number of services used by each beneficiary has more than doubled.

The administration is proposing the adoption of prospective payment systems for each service to gain better control over expenditures. While prospective payments encourage control of costs, it is important in designing such systems to be mindful of the incentives created regarding the quantity and quality of the services providers will deliver.

Selection of the unit of service for payment and taking account of the varying needs of patients for different types of services are important aspects of the design because of the incentives they create. Also important is the reliability of the cost and utilization data used to compute rates. A good design can be overwhelmed by bad data.

We understand the administration will develop an SNF prospective payment system, PPS, that would pay per diem rates covering all facility costs, an essential step given the substantial growth in ancillary service costs that has driven recent spending increases.

Payments would also be adjusted for differences in patient case mix. In contrast, the Balanced Budget Act of 1995 proposed development of a PPS based on an episode of care as the unit of service.

Establishing appropriate per-episode payment rates could be very challenging. Substantial variations exist in the average resources needed on a daily basis to treat beneficiaries with similar conditions making case mix adjustments for per diem rates rather challenging. Even more variation and less predictability exists for entire episodes. Moreover, payment on an episode basis may result in some SNFs inappropriately reducing the number of covered days. Both factors, we believe, make a day of care seem the better candidate for the unit of service for SNF payment. Using days as the basis for payment, however, gives no incentives to control length of stay making essential continued investment in claims review to avoid inappropriate increases in days, as well as in overall caseloads.

As far as the adequacy of HCFA's SNF data for setting prospective rates, we have concerns. Cost report audits are the primary means available to ensure that SNF cost reports reflect only allowable costs. But the percentage of SNFs subjected to field audits has decreased, as has the thoroughness of the audits that have been conducted.

We think it would be prudent for HCFA to do a thorough audit of a projectable sample of SNF cost reports. The results could be then used to adjust cost report data bases to help ensure that unallowable costs are not the base for prospective rate setting.

Turning to the administration's proposal for home health prospective payment, the information we have available is very general saying only that a prospective payment system for an appropriate unit of service would be developed by 1999. Again, the choice of a unit of service is crucial and there is limited understanding of the need for and the content of home health services to guide that choice.

Paying per visit would allow agencies to gain by attempting to shorten the length of visits and to increase their number. The net result may be higher total costs for Medicare with increasing numbers of visits as the cause just as they are today.

Payment for an episode, such as care for a 30- or a 100-day period, creates the risk that incentives to control resources result in too few visits and lower quality of care. While paying for episodes may better control spending, HCFA would need a method to ensure that beneficiaries receive adequate services and that any reduction in services that can be accounted for by past overprovision does not result in windfall profits to agencies.

In addition, HCFA would need to be vigilant to ensure that patients meet coverage requirements because agencies would be rewarded for increasing their caseloads. We have the same concerns about the quality of HCFA's home health care cost report data bases for prospective payment system rate setting purposes as we do for the SNF data base. Again, we suggest that a projectable sample be chosen and audited in order to establish a reasonable data base for the future.

We are also concerned about the appropriateness of using current Medicare data on the frequency of visits to establish prospective rates. As we reported last year, controls over the use of home health care are virtually nonexistent. We believe it would be prudent for HCFA to conduct thorough onsite medical reviews of a projectable sample of agencies to give it a basis to adjust utilization rates for purposes of establishing prospective payments.

Finally, the administration has also announced it will propose requiring SNFs to bill Medicare for all services provided to their beneficiary residents, except for physician and some practitioner services. We support this proposal, as we did in a September 1995 letter to you, Mr. Chairman. We and the HHS Inspector General have reported on the problems, such as overutilization of supplies that can arise when suppliers bill separately for services for SNF residents.

A consolidated billing requirement would make it easier for Medicare to identify all services furnished to residents which, in turn, would make it easier to control payments for those services.

In conclusion, it is clear that current payment systems for providers of skilled nursing and home health services to Medicare beneficiaries need to be revised. As more details concerning the administration's or other proposals emerge, we would be happy to work with the Subcommittee and others to help sort out the potential implications of suggested revisions.

I would be happy to answer any questions that you or Members of the Subcommittee may have.

Thank you.

[The prepared statement and attachments follow:]

Statement of William J. Scanlon, Ph.D., Director, Health Financing and Systems Issues, Health, Education, and Human Services Division, U.S. General Accounting Office; Accompanied by Thomas Dowdal, Senior Assistant Director, Health Financing and Systems Issues

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss Medicare's skilled nursing facility (SNF) and home health care benefits and the administration's forthcoming legislative proposals related to them. After relatively modest growth during the 1980s, Medicare's expenditures for SNFs and home health care have grown rapidly in the 1990s. SNF payments increased from $2.8 billion in 1989 to $11.3 billion in 1996, while home health care costs grew from $2.4 billion to $17.7 billion over the same period. Over that period, annual growth averaged 22 percent for SNFs and 33 percent for home health care.

My comments today will specifically focus on the reasons for cost growth for SNFs and home health care and the administration's announced legislative proposals for these two Medicare benefits. The information presented today is based mainly on our previous work. We also examined recent data on the two benefits from the Health Care Financing Administration (HCFA), which manages Medicare. The detailed legislative proposals are not yet available from the administration, so we reviewed the summaries of them that have been publicly released and talked with HCFA officials about these summaries.

In brief, Medicare's SNF costs have grown primarily because a larger portion of beneficiaries use SNFs than in the past and because of a large increase in the provision of ancillary services. For home health care costs, both the number of beneficiaries and the number of services used by each beneficiary have more than doubled. A combination of factors led to the increased use of both benefits:

- legislation and coverage policy changes in response to court decisions liberalized coverage criteria for the benefits, enabling more beneficiaries to qualify for care;
- these changes also transformed the nature of home health care from primarily posthospital care to more long-term care for chronic conditions;
- earlier discharges from hospitals led to the substitution of days spent in SNFs for what in the past would have been the last few days of hospital care, and increased use of ancillary services, such as physical therapy, in SNFs; and
- a diminution of administrative controls over the benefits, resulting at least in part from fewer resources being available for such controls, reduced the likelihood of inappropriately submitted claims being denied.

The major proposals by the administration for both SNFs and home health care are designed to give the providers of these services increased incentives to operate efficiently by moving them from a cost reimbursement to a prospective payment system. However, what remains unclear about these proposals is whether an appropriate unit of service can be defined for calculating prospective payments and whether HCFA's databases are adequate for it to set reasonable rates. The administration is also proposing that SNFs be required to bill for all services provided to their Medicare residents rather than allowing outside suppliers to bill. This latter proposal has merit, because it would make control over the use of ancillary services significantly easier.

Background

Medicare covers up to 100 days of care in a SNF after a beneficiary has been hospitalized for at least 3 days. To qualify for the benefit, the patient must need skilled nursing or therapy on a daily basis. For the first 20 days of SNF care, Medicare pays all the costs, and for the 21st through the 100th day, the beneficiary is responsible for daily coinsurance of $95 in 1997.

To qualify for home health care, a beneficiary must be confined to his or her residence ("homebound"); require part-time or intermittent skilled nursing, physical therapy, or speech therapy; be under the care of a physician; and have the services furnished under a plan of care prescribed and periodically reviewed by a physician. If these conditions are met, Medicare will pay for skilled nursing; physical, occupational, and speech therapy; medical social services; and home health aide visits. Beneficiaries are not liable for any coinsurance or deductibles for these home health services, and there is no limit on the number of visits for which Medicare will pay.

Medicare pays SNFs and home health agencies on the basis of their reasonable costs—those that are found to be necessary and related to patient care—up to specified cost limits. For SNFs, limits are imposed on the amount of routine costs—those for general nursing, room and board, and administrative overhead—that will be reimbursed. Separate limits are set for freestanding SNFs in urban and rural areas at 112 percent of mean routine costs. Hospital-based SNF limits are set midway between the freestanding limits and 112 percent of the mean routine costs of hospital-based SNFs in each area. Home health agency cost limits are established at 112 percent of the mean costs of freestanding agencies in urban and rural areas. Hospital-based agencies have the same limits. Separate limits are set for each type of visit (skilled nursing, physical therapy, and so on) but are applied in the aggregate; that is, an agency's costs over the limit for one type of visit can be offset by costs below the limit for another. Both SNF and home health cost limits are adjusted for differences in wage levels across geographic areas. Also, exemptions from and exceptions to the cost limits are available to SNFs and home health agencies that meet certain conditions.

While the cost-limit provisions of Medicare's cost reimbursement system for SNFs and home health agencies give some incentives for providers to control the affected costs, these incentives are considered by health financing experts to be relatively weak, especially for providers with costs considerably below their limit. On the other hand, it is generally agreed that prospective payment systems (PPS) give providers increased cost-control incentives. The administration proposes establishing PPSs for SNF and home health care and estimates that Medicare savings exceeding $10 billion would result over the next 5 fiscal years.

SNF and Home Health Cost Growth

The Medicare SNF and home health benefits are two of the fastest growing components of Medicare spending. From 1989 to 1996, Medicare part A SNF expenditures increased over 300 percent from $2.8 billion to $11.3 billion. During the same period, part A expenditures for home health increased from $2.4 billion to $17.7 billion—an increase of over 600 percent. SNF and home health payments currently represent 8.6 percent and 13.5 percent of part A Medicare expenditures, respectively.

At Medicare's inception in 1966, the home health benefit under part A provided limited posthospital care of up to 100 visits per year after a hospitalization of at least 3 days. In addition, the services could only be provided within 1 year after the patient's discharge and had to be for the same illness. Part B coverage of home health was limited to 100 visits per year. These restrictions under part A and part B were eliminated by the Omnibus Reconciliation Act of 1980 (ORA, P.L. 96–499), but little immediate effect on Medicare costs occurred.

With the implementation of the Medicare inpatient PPS in 1983, the utilization of the SNF and home health benefits was expected to grow as patients were discharged from the hospital earlier in their recovery periods. However, HCFA's relatively stringent interpretation of coverage and eligibility criteria held growth in check for the next few years. As a result of court decisions in the late 1980s, HCFA issued guideline changes for the SNF and home health benefits that had the effect of liberalizing coverage criteria, thereby making it easier for beneficiaries to obtain SNF and home health coverage. Additionally, the changes prevent HCFA's claims processing contractors from denying physician-ordered SNF or home health services unless the contractors can supply specific clinical evidence that indicates which particular services should not be covered.

The combination of these legislative and coverage policy changes has had a dramatic effect on utilization of these two benefits in the 1990s, both in terms of the number of beneficiaries receiving services and in the extent of these services. (App. I contains figures that show growth in SNF and home health expenditures in relation to the legislative and policy changes.) For example, ORA 1980 and HCFA's 1989 home health guideline changes have essentially transformed the home health benefit from one focused on patients needing short-term care after hospitalization to one that serves chronic, long-term care patients as well. The number of bene-

ficiaries receiving home health care more than doubled in the last few years, from 1.7 million in 1989 to about 3.9 million in 1996. During the same period, the average number of visits to home health beneficiaries also more than doubled, from 27 to 72. In a recent report on home health, we found that from 1989 to 1993, the proportion of home health users receiving more than 30 visits increased from 24 percent to 43 percent and those receiving more than 90 visits tripled, from 6 percent to 18 percent, indicating that the program is serving a larger proportion of longer-term patients. Moreover, about a third of beneficiaries receiving home health care did not have a prior hospitalization, another possible indication that chronic care is being provided.

Similarly, the number of people receiving care from SNFs has also almost doubled, from 636,000 in 1989 to 1.1 million in 1996. While the average length of a Medicare-covered SNF stay has not changed much during that time, the average Medicare payment per day has almost tripled—from $98 in 1990 to $292 in 1996. Use of ancillary services, such as physical and occupational therapy, has increased dramatically and accounts for most of the growth in per-day cost. For example, our analysis of 1992 through 1995 SNF cost reports shows that reported ancillary costs per day have increased 67 percent, from $75 per day to $125 per day, while reported routine costs per day have increased only 20 percent, from $123 to $148. Unlike routine costs, which are subject to limits, ancillary services are only subject to medical necessity criteria, and relatively little review of their use is done by Medicare. Moreover, SNFs can cite high ancillary service use to justify an exception to routine service cost limits, thereby increasing routine service payments.

Between 1990 and 1996, the number of hospital-based SNFs increased over 80 percent, from 1,145 such agencies to 2,088. Hospitals can benefit from establishing a SNF unit in a number of ways. Hospitals receive a set fee for a patient's entire hospital stay, based on a patient's diagnosis related group (DRG). Therefore, the quicker that hospitals discharge a patient into a SNF, the lower that patient's inpatient hospital care costs are. We found that in 1994, patients with any of 12 DRGs commonly associated with posthospital SNF use had 4 to 21 percent shorter stays in hospitals with SNF units than patients with the same DRGs in hospitals without SNF units. Additionally, by owning a SNF, hospitals can increase their Medicare revenues through receipt of the full DRG payment for patients with shorter lengths of stay and a cost-based payment after the patients are transferred to the SNF.

Rapid growth in SNF and home health expenditures has been accompanied by decreased, rather than increased, funding for program safeguard activities. For example, our March 1996 report found that part A contractor funding for medical review had decreased by almost 50 percent between 1989 and 1995. As a result, while contractors had reviewed over 60 percent of home health claims in fiscal year 1987, their review target had been lowered by 1995 to 3.2 percent of all claims (or even, depending on available resources, to a required minimum of 1 percent). We found that a lack of adequate controls over the home health program, such as little intermediary medical review and limited physician involvement, makes it nearly impossible to know whether the beneficiary receiving home care qualifies for the benefit, needs the care being delivered, or even receives the services being billed to Medicare. Also, because of the small percentage of claims now selected for review, home health agencies that bill for noncovered services are less likely to be identified than was the case 10 years ago. Similarly, the low level of review of SNF services makes it difficult to know whether the recent increase in ancillary use is medically necessary (for example, because patient mix has shifted toward those who need more services) or simply a way for SNFs to get more revenues.

Finally, because relatively few resources are available for auditing end-of-year provider cost reports, HCFA has little ability to identify whether home health agencies or SNFs are charging Medicare for costs unrelated to patient care or other unallowable costs. Because of the lack of adequate program controls, it is quite possible that some of the recent increase in home health and SNF expenditures stems from abusive practices. The Health Insurance Portability and Accountability Act of 1996 (P.L. 104–191), also known as the Kassebaum-Kennedy Act, has increased funding for program safeguards. However, per-claim expenditures will remain below the level in 1989, after adjusting for inflation. We project that, in 2003, payment safeguard spending as authorized by Kassebaum-Kennedy will be just over one-half of the 1989 per-claim level, after adjusting for inflation.

Administration's Proposals for Prospective Payment Systems

The goal in designing a PPS is to ensure that providers have incentives to control costs and that, at the same time, payments are adequate for efficient providers to furnish needed services and at least recover their costs. If payments are set too

high, Medicare will not save money and cost-control incentives can be weak. If payments are set too low, access to and quality of care can suffer.

In designing a PPS, selection of the unit of service for payment purposes is important because the unit used has a strong effect on the incentives providers have for the quantity and quality of services they provide. Taking account of the varying needs of patients for different types of services—routine, ancillary, or all—is also important. A third important factor is the reliability of the cost and utilization data used to compute rates. Good choices for unit of service and cost coverage can be overwhelmed by bad data.

Proposal for a SNF PPS

We understand that the administration will propose a SNF PPS that would pay per diem rates covering all facility cost types and that payments would be adjusted for differences in patient case mix. Such a system is expected to be similar to HCFA's ongoing SNF PPS demonstration project that is testing the use of per diem rates adjusted for resource need differences using the Resource Utilization Group, version III (RUG–III) patient classification system.[4] This project was recently expanded to include coverage of ancillary costs in the prospective payment rates.

An alternative to the proposal's choice of a day of care as the unit of service is an episode of care—the entire period of SNF care covered by Medicare. While substantial variation exists in the amount of resources needed to treat beneficiaries with the same conditions when viewed from the day-of-care perspective, even more variation exists at the episode-of-care level. Resource needs are less predictable for episodes of care. Moreover, payment on an episode basis may result in some SNFs inappropriately reducing the number of covered days. Both factors make a day of care the better candidate for a PPS unit of service. Furthermore, the likely patient classification system, RUG–III, is designed for and being tested in a per diem PPS. On the other hand, a day-of-care unit gives few, if any, incentives to control length of stay, so a review process for this purpose would still be needed.

The states and HCFA have a lot of experience with per diem payment methods for nursing homes under the Medicaid program, primarily for routine costs but also, in some cases, for total costs. This experience should prove useful in designing a per diem Medicare PPS.

Regarding the types of costs covered by PPS rates, a major contributor to Medicare's SNF cost growth has been the increased use of ancillary services, particularly therapy services. This, in turn, means that it is important to give SNFs incentives to control ancillary costs, and including them under PPS is a way to do so. However, adding ancillary costs does increase the variability of costs across patients and place additional importance on the case-mix adjuster to ensure reasonable and adequate rates.

Turning to the adequacy of HCFA's databases for SNF PPS rate-setting purposes, our work, and that of the Department of Health and Human Services' (HHS) Inspector General, has found examples of questionable costs in SNF cost reports. For example, we found extremely high charges for occupational and speech therapy with no assurance that cost reports reflected only allowable costs.[5] Cost report audits are the primary means available to ensure that SNF cost reports reflect only allowable costs. However, the resources expended on auditing cost reports have been declining in relation to the number of SNFs and SNF costs for a number of years. The percentage of SNFs subjected to field audits has decreased as has the extent of auditing done at the facilities that are audited. Under these circumstances, we think it would be prudent for HCFA to do thorough audits of a projectable sample of SNF cost reports. The results could then be used to adjust cost report databases to remove the influence of unallowable costs, which would help ensure that inflated costs are not used as the base for PPS rate setting.

Proposal for a Home Health PPS

The summary of the administration's proposal for a home health PPS is very general, saying only that a PPS for an appropriate unit of service would be established in 1999 using budget neutral rates calculated after reducing expenditures by 15 percent. HCFA estimates that this reduction will result in savings of $4.7 billion over fiscal years 1999 through 2002.

The choice of the unit of service is crucial, and there is limited understanding of the need for and content of home health services to guide that choice. Choosing either a visit or an episode as the unit of service would have implications for both cost control and quality of care, depending on the response of home health agencies. For example, if the unit of service is a visit, agencies could profit by shortening the length of visits. At the same time, agencies could attempt to increase the number of visits, with the net result being higher total costs for Medicare, making the per-

visit choice less attractive. If the unit of service is an episode of care over a period of time such as 30 or 100 days, agencies could gain by reducing the number of visits during that period, potentially lowering quality of care. For these reasons, HCFA needs to devise methods to ensure that whatever unit of service is chosen will not lead to increased costs or lower quality of care. If an episode of care is chosen as the unit of service, HCFA would need a method to ensure that beneficiaries receive adequate services and that any reduction in services that can be accounted for by past overprovision of care does not result in windfall profits for agencies. In addition, HCFA would need to be vigilant to ensure that patients meet coverage requirements, because agencies would be rewarded for increasing their caseloads. HCFA is currently testing various PPS methods and patient classification systems for possible use with home health care, and the results of these efforts may shed light on the unit-of-service question.

We have the same concerns about the quality of HCFA's home health care cost report databases for PPS rate-setting purposes as we do for the SNF database. Again, we believe that adjusting the home health databases, using the results of thorough cost report audits of a projectable sample of agencies, would be wise.

We are also concerned about the appropriateness of using current Medicare data on visit rates to determine payments under a PPS for episodes of care. As we reported in March 1996, controls over the use of home health care are virtually nonexistent. Operation Restore Trust, a joint effort by federal and state agencies in several states to identify fraud and abuse in Medicare and Medicaid, found very high rates of noncompliance with Medicare's coverage conditions in targeted agencies. For example, in a sample of 740 beneficiaries drawn from 43 home health agencies in Texas and 31 in Louisiana that were selected because of potential problems, some or all of the services received by 39 percent of the beneficiaries were denied. About 70 percent of the denials were because the beneficiary did not meet the homebound definition. Although these are results from agencies suspected of having problems, they illustrate that substantial amounts of noncovered care are likely to be reflected in HCFA's home health care utilization data. For these reasons, it would also be prudent for HCFA to conduct thorough on-site medical reviews of a projectable sample of agencies to give it a basis to adjust utilization rates for purposes of establishing a PPS.

Consolidated Billing for SNFs

The administration has also announced that it will propose requiring SNFs to bill Medicare for all services provided to their beneficiary residents except for physician and some practitioner services. We support this proposal as we did in a September 1995 letter to you, Mr. Chairman. We and the HHS Inspector General have reported on problems, such as overutilization of supplies, that can arise when suppliers bill separately for services for SNF residents.

A consolidated billing requirement would make it easier for Medicare to identify all the services furnished to residents, which in turn would make it easier to control payments for those services. The requirement would also help prevent duplicate billings for supplies and services and billings for services not actually furnished by suppliers. In effect, outside suppliers would have to make arrangements with SNFs under such a provision so that nursing homes would bill for suppliers' services and would be financially liable and medically responsible for the care.

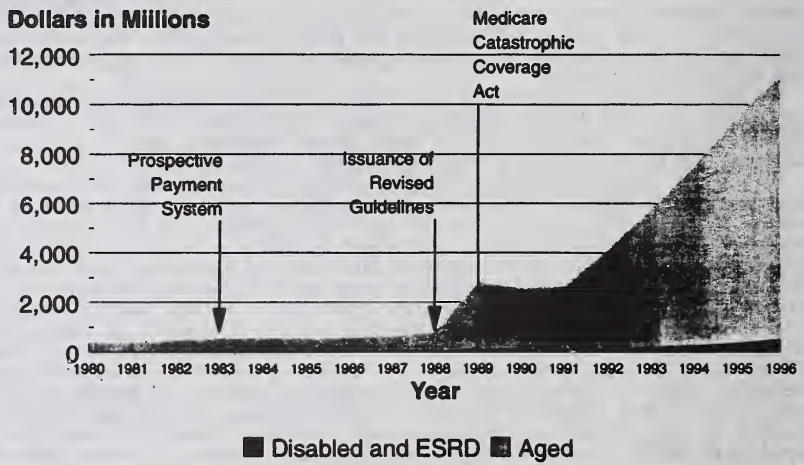
In conclusion, it is clear that the current payment systems for providers of skilled nursing and home health services to Medicare beneficiaries need to be revised. As more details concerning the administration's or others' proposals for revising those systems become available, we would be glad to work with the Subcommittee and others to help sort out the potential implications of suggested revisions.

This concludes my prepared remarks, and I will be happy to answer any questions.

For more information on this testimony, please call William Scanlon on (202) 512–7114 or Thomas Dowdal, Senior Assistant Director, on (202) 512–6588. Patricia Davis also contributed to this statement.

MEDICARE SKILLED NURSING FACILITY AND HOME HEALTH EXPENDITURES, 1980-96

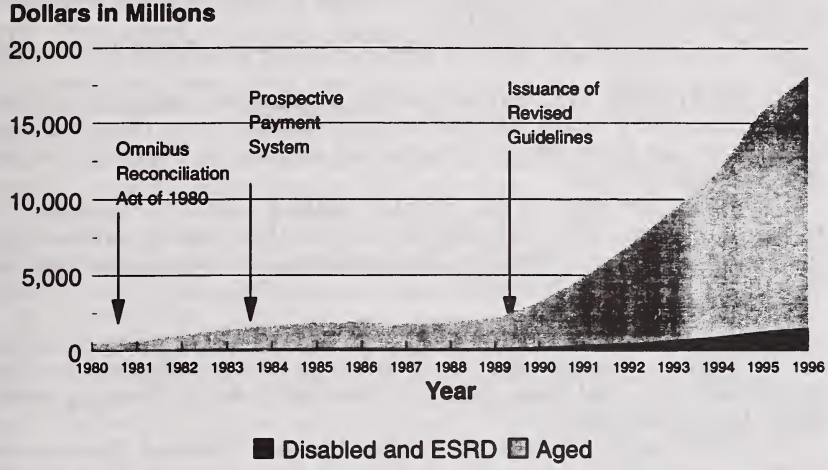
Figure I.1: Medicare Skilled Nursing Facility Expenditures, 1980-96



Note: ESRD = end-stage renal disease.

Source: HCFA's Office of the Actuary.

Figure I.2: Medicare Home Health Expenditures, 1980-96



Note: ESRD = end-stage renal disease.

Source: HCFA's Office of the Actuary.

Chairman THOMAS. Thank you very much, Dr. Scanlon.

Dr. Newhouse, based upon the testimony in part by Dr. Scanlon and Mr. Grob, where are you, where is ProPAC on a per diem versus episodic payment on SNFs?

Have you formed an opinion and if so, what is it and if not, why not?

Mr. NEWHOUSE. We have supported prospective payment and the Commission as a whole has not taken a position with respect to per episode or per diem. My own views are similar to, I think, to what Mr. Scanlon told you.

Chairman THOMAS. Well, Scanlon talked about the concern in terms of the way in which you dealt with the episodic over a time period and the incentives are disincentives for the structuring. Do you tend to agree with that?

Mr. NEWHOUSE. Yes.

Chairman THOMAS. And what is the downside of going to a per diem? I think I understand the upside, we spent more time looking at episodic the first time, what is the downside of thinking about going to the per diem?

Mr. NEWHOUSE. Well, to the degree that one believes there is excessive numbers of days, then keeping a payment out there for an extra day, obviously, only enhances that.

Chairman THOMAS. Well, I started off with my statement saying there is not going to be any perfect system and, frankly, anything is better than what we have.

Although, clearly, if we have a choice between several, I would like to make sure we understand the upsides and the downsides. And my guess is as we combine them with other factors, they become more or less important.

Mr. NEWHOUSE. I would have said as the ability to do case mix adjustment improves, one could move more toward an episode system or one would tilt more toward an episode system. But in the absence of a good case mix adjustor that would explain variation across beneficiaries in their use patterns, I personally would tilt toward the per diem.

Chairman THOMAS. Is it more difficult to try to develop a case mix adjustor when you have got two significantly different universes of people who use it, both in terms of short term and long term?

Mr. NEWHOUSE. Yes, it is.

Chairman THOMAS. And what are the odds of us getting out of HCFA a case mix adjustor that really does serve our purposes?

Mr. NEWHOUSE. For home health?

Chairman THOMAS. Yes.

Mr. NEWHOUSE. I think they are very low.

Chairman THOMAS. I am going to jump back and forth between skilled nursing and home health because I do not want to take a lot of time following one track and then going back and following the other.

Mr. NEWHOUSE. OK, fine.

Chairman THOMAS. I am going to jump back and forth.

Mr. NEWHOUSE. They are a little different in that for a case mix adjustment I think one of the things one might imagine is that the support system in the home, for example, has a good bit to do with the number of home health visits one might want to pay for which would be a lesser consideration with the skilled nursing.

We know the diagnosis does not predict this. We do not really have data bases that have things like support systems in home on any great numbers of people and, as Dr. Scanlon mentioned, we do not have a uniform definition of a visit. So, it is hard to know exactly what services were delivered out there and that we were paying for.

In short, the kind of raw materials we would have for a case mix system are not really there in the short run.

Chairman THOMAS. I would suggest it is harder than that because not only do we not have a clear definition for a visit, and I have got a couple of questions on that, but I do not know that we have a comfortable definition of homebound.

Mr. NEWHOUSE. Right, we agree with you. In fact, we think we do not or we have a definition but we think it is very difficult to enforce and is probably applied differentially across the country.

Chairman THOMAS. I think we have pretty good evidence of that. Just like visits. There is a regional—I saw a clear regional difference and I want to pursue that with another panel. There appeared to be a south-southeast bias.

Anyone have any possible explanation for that because when I see a region like that rather than particular areas, it tends to be the way in which people view or deliver care.

Mr. GROB. The southeastern difference was in one of our reports and it was exactly that—four southeastern States which had a remarkably higher average number of visits per person. But we cannot account for it either. It could be either the practice in the area because people do tend to copy from one another or it could be the amount of supervision and the way the bills are paid by the carrier serving those areas, and we cannot tell which one it is.

Chairman THOMAS. Well, going back to the visit question. In your testimony, you say the parameters should be set on the number of visits a beneficiary receives for a specified condition.

If we do not have a good way to measure the duration of a visit, how can we set parameters around the number of visits? When one visit may be one-quarter of an hour and another visit may be 1 hour, how are we going to pay when we do not define what a visit is.

Now, ProPAC has suggested a couple of recommendations in terms of what a visit is.

Mr. GROB. My opinion on home health is that we will not succeed in reducing costs or controlling costs by using a per-visit limit or per diem type limit. That is basically where we are right now because there is a cap that Medicare——

Chairman THOMAS. Could we not at least begin a coding system so that we can, or notwithstanding our ability to make those kinds of decisions, we can at least put apples in one bin and oranges in another by the way in which they define what they do and how long they do it. Is that not a step forward? I think ProPAC recommends that.

Anybody, but, Mr. Grob started, so, let him if he wants to finish. If he does not, then we can go over to Dr. Scanlon.

Mr. GROB. Just a couple of quick opinions. And as you said, there are so many different ways to go in this. Right now, Medicare has——

Chairman THOMAS. That is our problem, but we are going to narrow it down to those that are best for us to move forward.

Mr. GROB [continuing]. Medicare already has a limit on how much we pay per visit no matter what happens during that visit. And virtually all of the home health agencies are charging right up to that limit. So, for all practical purposes, we already have a flat rate per limit and that is what has got us into the bind where the motivation is then to increase the number of visits. So, I think flat out, that will not work for home health.

I think we have got to go to something that is more per episode unless we tried to distinguish what was happening in the home. But right now, the resources that are required to certify or recertify a home health agency or to scrutinize a bill are just not there under the current system. To think we would be able to set up a system where we could determine whether it was this kind of visit or that kind of visit and whether it was properly billed, I think that for all practical purposes there would be no way whatsoever to administer a system with that much detail in it. We cannot even manage a system with the detail that we have in it now.

Dr. SCANLON. It is our understanding that Health Care Financing Administration has recognized the problem of the lack of a definition of a visit and in their current research is beginning to address that by trying to measure both the times that are involved in different visits as well as the content to see if they can come up with a typology that would be able to categorize visits.

It is important, even though we believe that a per-episode payment makes sense for home health, to remember that dealing with both the long stayer and the short stayer within a home health episode is a difficult challenge. And it may be we need a transition period where we can have an episode as was defined in the Balanced Budget Act for the initial portion of an episode or the initial portion of a home health stay. And then we need to pay per visit subsequent to that. And at that point, it will begin being important for us to understand what constitutes a visit and what different types of visits we should be taking into account.

Chairman THOMAS. Well, one approach would be to clearly indicate what we think is appropriate and then when someone does not do what is appropriate, you can go after them. And Mr. Grob, your testimony, especially in the first few pages, every paragraph began with waste, fraud and abuse, and a high degree of fraud in terms of the examples that you gave.

You have two approaches to that. One, restructure the system so that it is absorbed under some kind of a prospective system or outlined very clearly and then as the saying goes, have a few public hangings because frankly, people are learning how to game the system in terms of going as far as they can. If they find out there is a clear understanding of what you can and cannot do, that information, I think, travels through the system as well.

In that respect, when you look at the President's proposal on home health, does the President respond in the system that he is advocating to your concerns about fraud and abuse?

Mr. GROB. There are a couple of ways in which the interim system that the President is proposing is responsive to some of our concerns. One of the things the President is proposing is——

Chairman THOMAS. You do not think he is responsive to all of your concerns?

Mr. GROB. No. Because—but for the reason that you named at the beginning of this—I think we will be a long way from creating a perfect system here, only for that reason, not for any other reason.

We support——

Chairman THOMAS. Well, I am only interested in that line of questioning—if you have examined the ways in which the President is responsible to some of your concerns—if you have suggestions that we could look at in terms of adding to or modifying the President's proposal so that it would address all of your concerns?

Mr. GROB. We believe that even though it may seem to be a drastic solution that some approaches that are very simple, like having limits on the number of visits per episode or financial limits on the amount paid per episode is probably a good approach that could allow for something you suggested which would be, you might have such a limit and then if it were surpassed, perhaps an application could be made for permission to add more service on it.

So, there may be ways to allow an exception with some criteria there that could provide for the person that just does not quite fit the mold.

So, there are a number of ideas. What we tried to do is put as many different ideas in as possible. Our concern is primarily that we do something soon because as time goes by we are going to lose a lot more money.

Chairman THOMAS. OK. Thank you very much.

The gentleman from California.

Mr. STARK. Thank you, Mr. Chairman. I just want to see if I am getting to where the areas for concern might be. Above 120 visits per episode is about 80 percent of the cost for the Health Care Financing Administration. Is that right, Joe, according to your information? If you take 120 visits, somewhere in the 70- to 80-percent range of all the costs are in that area?

Mr. NEWHOUSE. Yes. The number of visits accounted for by people using over 100 is two-thirds.

Mr. STARK. Give me some poetic license here. In those visits, I am informed that 60 or 70 percent of those visits are made by virtually unskilled people, aides, right?

Mr. GROB. It is true that as the number of visits per home health agency go up, that the greater the proportion of the——

Mr. NEWHOUSE. That is in my chart 6, Mr. Stark.

Mr. STARK. OK. It is about 60 percent, am I right or what?

Mr. NEWHOUSE. Yes. In that group of people getting 120.

Mr. STARK. These aides are people at the outside making $6 to $8 an hour. And yet, the average cost for a visit is about $40. Now, does anybody have any figures on what the average time per visit is? Do you have any information on that? Nobody? Dr. Scanlon?

Dr. SCANLON. No, I do not.

Mr. STARK. I will bet you it is not much longer than 1 hour. It might be 2 hours, it might be 3 hours. But it just seems to me that between paying these minimum wage people $5, $10, $15 and collecting $40 there is an awful lot of overhead and room to wiggle in there.

I could see why there is a great urgency to schedule a lot more visits. That is pretty outrageous I think. I am all for finding employment for unskilled and low-skilled workers, and we just passed a bill in this Subcommittee that is going to encourage putting a lot of people to work. But I do not know as we were trying to add a lot of overhead. Am I misleading myself in thinking that we have a lot of overhead and not much productivity in this area of the high number of visits?

Mr. DOWDAL. I think that is why we are talking about the need for some better cost report audits than have been done so that we can find out how much of that is legitimate and how much of it is not.

Mr. STARK. OK. And while you raise that, my good friends, let me quote, "GAO found that proprietary agencies"—that means for-profit? In words that I can understand, OK.

Mr. DOWDAL. Right.

Mr. STARK. OK. "For profit agencies consistently provide more home health visits in all areas of the country than nonprofit. In 1993 they provided beneficiaries 78 visits a year while their voluntary nonprofit and/or government agencies provided an average of 46 visits per year.

"An analysis of beneficiaries with one of four frequently occurring diagnoses shows that proprietary agencies provide significantly more visits than nonprofits for beneficiaries with the same primary diagnosis."

Now, can you find any reason why proprietary home health agencies provide more visits than do nonprofit, except as might be related to car and boat payments by the proprietors?

Mr. NEWHOUSE. We certainly did not examine that linkage. [Laughter.]

However, we did carry the analysis forward to try and control for diagnosis because it is often cited that an agency or a provider will have a different kind of case mix than others. And controlling it for diagnosis and looking at a large cross section of these agencies by region, by State, by the whole country, we find these kinds of differences and it is not possible to try and explain those differences other than potentially the philosophy of the agencies providing those type of services.

Mr. STARK. If our effort is to get quality care to our beneficiaries at the least cost to the taxpayer, is there anything that any of you found in the method of operation of current home health agencies that you would recommend to us as setting a good example for achieving that goal of quality care delivered at a reasonable price? Or are we faced with the idea of just scrubbing the present system and basically starting from scratch?

Mr. GROB. Mr. Stark, one of the studies we did was precisely that. We tried to find out what the lower cost agencies were doing

and one of our reports has descriptions of what they were doing to control their costs.

We found no difference in the official statements of mission or operating procedures, things of this nature. But in terms of just the daily grind of carrying out the program, those lower cost agencies were obviously more attentive to the types of services their patients were receiving. They were monitoring the care, they were using case managers, a number of things like that. If you do not have that report, I will make sure you do. We did take a look at that question.

Mr. STARK. They were providing tender, loving care?

Mr. GROB. That is what they would say and when we examined them and we sent people out to look at what they were doing, they certainly seemed to be doing that.

Mr. STARK. Could you suggest how we could write that into legislation?

Mr. GROB. I do not know how to do that. But I——

Chairman THOMAS. I suggest you have it now.

Mr. GROB. OK. I think that again, something that attaches a limit or standard on the number of visits would do that in looking at exceptions.

If I could just give you an anecdote that may come to play here. If we were to think you needed more than 100 visits to ensure quality of care, then we would have to be making a statement that all those health agencies that are using 30 visits per episode are not providing for good quality of care. And I just do not believe that is the case.

A couple of times I had to give a speech on this and when the speech was over it was to large groups of people in home health agencies, I had a lot of people come running up to me from the home health agencies saying, Mr. Grob, please do not stop saying what you are saying, because I can tell you we have been in this business a long time, we give about 30 visits a year, we take care of our patient, and a lot of other people are doing a lot more visits for that. We really do not think they are adding much to it.

Mr. STARK. I think we have a problem, Mr. Chairman.

Thank you.

Chairman THOMAS. And we will hear testimony later, but I would just tell you that I was a bit surprised that managed care was dealing with an $882 a year cost and fee-for-service was at $3,400.

Mr. GROB. That is correct.

Chairman THOMAS. And the information was that people were leaving the managed care to go to the fee-for-service. I guess the question that came to mind when I was reading it was, Yes, what else is not obvious when someone gets four times the amount of benefits. What concerns me is that there is then some assumption that the managed care benefit is somehow less or unacceptable because people are leaving that one and going to the 4-for-1 benefit. And I can assure these folks talk to each other.

Now, they would not do it at the senior center because they are homebound. And they cannot leave their home, so they have to do it over the telephone. But when they start comparing what they are getting, it is fairly obvious what the incentive for leaving the

program is, which may or may not have a quality aspect to it. For one, when you get a fourfold multiplier by voting with your feet, my question is, Why does anybody stay in the other program?

Mr. GROB. And the health maintenance organizations are using case managers to monitor their patients very closely, and also, when they choose the home health agencies that they will use for the care of their patients, they tend to want to use home health agencies that have been accredited. They tend to look for measures of quality. They want to make sure they do have a quality organization.

Chairman THOMAS. I apologize to the gentleman from Louisiana, he is next; but I just want to ask one question, you mentioned it there, and I do not want to leave it hanging.

Is it possible, as we move forward, to think about the idea of, especially for these folks, dealing with the kind of a case manager, notwithstanding the fact that they would be in fee-for-service? Is that something that makes sense?

Mr. GROB. Again, we think it makes sense.

Chairman THOMAS. The gentleman from Louisiana.

Mr. MCCRERY. Mr. Chairman, so far, what I have heard today is a lot of good questions, but not many answers, and I am a bit confused. Everything that I read from—every witness so far says we ought to go toward some sort of prospective payment system but nobody really knows which prospective payment system we ought to go to.

And that poses us with a big problem, because these are the folks that are supposed to know at least as much as we do, and probably more.

And I have heard this case mix adjuster argument for several years now. Are we ever going to be able to come up with a case mix adjuster, or is this just something that we are going to keep talking about being desirable, and we are going to get good people working on it? But is it ever going to come to an end?

Are we ever going to have a case mix adjuster?

Mr. NEWHOUSE. Well, we are surely never going to have the perfect adjuster. We may be doing better than we are now. It is for this reason, Mr. McCrery, that we recommended two things. First of all, implementing some limits in the short run, which is consistent with the other testimony you have heard.

I do not think any of us would say do nothing until you have an adjuster. And second, we recommended a demonstration of linking the acute and the postacute payments, which we think might be a desirable way to go in the long run.

Mr. MCCRERY. OK. The other thing that seems to run through the testimony is the amount of oversight necessary by HCFA or somebody, if we are to do one or the other type of prospective payment system. Either way is going to require a lot of oversight.

It sounds to me as if we are to go with either of these choices of the unit of service, we are going to have to have a pretty big police force to police the efforts of the home health industry. That concerns me, Mr. Chairman, and I would like for maybe our panelists to expound upon that.

What do you envision for the scope of oversight by HHS, or HCFA, if we come up with one of these prospective payment systems in the unit of service?

Chairman THOMAS. Will the gentleman yield, briefly.

Mr. MCCRERY. Sure.

Chairman THOMAS. At the seminar the other day, Dr. Scanlon, I believe your chart clearly indicates when there was a court decision that required us to expand the coverage.

As I recall, you were talking, in the early days, of the percentage of reviews that were going on, and that was, in my estimation, as I recall, 60 percent——

Mr. SCANLON. Sixty percent of claims were reviewed prior to 1989.

Chairman THOMAS [continuing]. A full 60 percent of the claims were reviewed, and today it is——

Mr. SCANLON. Less than 3 percent.

Mr. NEWHOUSE. And that is because of the growth in claims, sir.

Mr. SCANLON. Well, it is both the growth in claims and a decline in the amount of funding for claims review activities, though the Health Insurance Portability Act restores some of that funding so there will be more moneys available in the future to conduct claims review. Now——

Chairman THOMAS. I guess my point is that we are never going to—notwithstanding the money we would make available—reach a 60-percent claims review level, not with the volume we have.

Mr. SCANLON. No, because again, we have a much larger volume, and we have also restored only a portion of the money. But the issue is we can get better about doing our claims review by trying to identify the types of claims and the providers that we should be targeting for review, so that it does not become an onerous burden for the average, well-performing home health agency, or skilled nursing facility. But a review of claims becomes something that people respect and do not submit inappropriate claims.

That is, I think, one of the important goals we should have in mind as we design a claims review system to complement any prospective payment system that we put into place, is that recognizing the prospective payment system will not be perfect.

Chairman THOMAS. Mr. Grob.

Mr. GROB. Mr. McCrery, I cannot estimate the resources that would be required, but I would tell you that it would take a lot fewer resources to monitor a prospective payment system than it does to monitor the system we have right now, because to be successful now, to really be successful, you would have to monitor a lot of the individual claims, claim by claim, a lot of the individual beneficiaries, beneficiary by beneficiary. Very difficult.

But monitoring the prospective payment system, you have a much smaller universe to monitor.

Mr. MCCRERY. Well, if we were to go to an episodic payment per episode, describe to me the type of oversight HHS would exercise in ensuring quality of care.

Mr. GROB. I think there, you would primarily have to worry whether the home health agency was, as a matter of practice, enrolling people that were eligible for the service rather than other

people. So you would have to focus on the methods it uses to enroll the people.

You would have to worry about the kind of staff it hires and the methods it uses to provide the benefit, and you would—let me see—there is the method to benefit the—and the payment. Primarily, those kind of things—how they conduct their work—and you could, then, perhaps get a better handle on the kind of outcomes they were having with the patients, and how the patients were doing.

So it would be a very different method. Right now, we have to worry a lot more about just a greater number of claims, and it is just very difficult to do.

Mr. NEWHOUSE. I would have two concerns, Mr. McCrery. One is that a lot of people discharged from a hospital could, with the current definition of the benefit, which is rather loose, justify a home health visit, and if there were not an adequate case mix adjuster and one simply paid the average, some kind of average, it could be extremely lucrative to provide a few visits to people being discharged from the hospital.

That is kind of the low end, if you will. At the high end, the concern is the opposite, that there are some people for whom a visit is very important, say, to give them a bath, and since the financial reward from an additional visit would not be there, the home health agency might cut back, inappropriately.

So those would be my two main concerns about going——

Mr. MCCRERY. Yes. How do you police those concerns, though? How do you satisfy those concerns?

Mr. NEWHOUSE. Clearly, the better you can get the financial incentives, the less burden you put on the policing/enforcement system. I think we are trying to do as well as we can with the financial incentives, which unfortunately, I think is not very good at the moment.

Mr. SCANLON. I also think that even though we are pessimistic about the perfect case mix adjuster, we should realize we can develop case mix adjusters that can distinguish between the extremes, and make the payments tied more closely to care at the two extremes.

The other thing I think I would be concerned about in terms of review of quality of care is that when we do our annual certifications of home health agencies, we look at the records of care that have actually been delivered and assess whether or not that care is appropriate. That is going to take more development of standards for care than we have today.

With the kind of variation we have been talking about, we do not understand what is the appropriate level given the wide range of experience we have observed.

Mr. MCCRERY. Well, Mr. Chairman, I just want to conclude by saying it seems to me we are on the verge of increasing government's role and influence in the health care system as we try to ensure all of these favorable outcomes for everybody, and that bothers me.

Perhaps we ought to look at going to a system that allows some discretion on the part of the beneficiaries as to what kind of services they purchase, and then have some kind of mandatory out-

comes, appraisal available for those beneficiaries, so they can make the determination for themselves, what to purchase and when to use it.

Chairman THOMAS. The gentleman has now pursued one of his stronger points, which I think is one that's well taken. I guess this bothers me as much as any, especially in the growth area of home health, in these therapies that have been added. Were that beneficiary to go to an outpatient hospital there would be a copayment involved. Were they to go to the professional therapist's office, there would be a copayment involved.

When they are home, and the therapy is brought to them, is there a copayment involved?

Mr. NEWHOUSE. No.

Chairman THOMAS. No, there is not. And so there is no disincentive in that side of the ledger, at all. There is no screening process, there is no requirement to hierarchically weigh what is being done in terms of a copayment on the part of the beneficiary, and I know you have always been a strong supporter of folks moving further the other way—this way.

The gentleman from California, Mr. Becerra.

Mr. BECERRA. Thank you, Mr. Chairman.

If I could just key off with the last comments. Do we have anything in the studies that have been done, the research that has been done, to give us some sense of what the beneficiaries believe they need as they receive this SNF, or home health care service? Is there anything that documents what beneficiaries are saying they need?

For example, all these ancillary services, are they the ones that are demanding them, or are they being provided them because the medical professional is saying, "You need this"?

Mr. NEWHOUSE. I am not aware of any such study.

Mr. GROB. As part of our beneficiary survey, we included some questions about the beneficiary's understanding of the home health benefit, and generally, they seem to understand that Medicare has a home health benefit and the eligibility for it, and they have a strong interest in it.

But they also do not seem to understand really well what it is that Medicare provides, and what the benefit eligibility is. So from that point of view, they are a little blind going into it, and I do think they take their cues from the providers.

Mr. BECERRA. And once they are in it, they are probably still blind.

Mr. GROB. That is right. I think a lot of the influence for whether care should be continued, and how much care, and what kind of care, comes from the influence of the providers themselves. Even though there is a requirement for the physician to certify off on that, once they are in the care, I think the physicians tend to follow the lead as well of the home health provider.

Mr. BECERRA. And if I could just express a concern that I would have, if we go toward a system where you let the beneficiary try to be more scrutinous of the services being provided, I know my parents, if a doctor or a health care provider would tell them, "You need this service," chances are they are going to take it, and pay for it, if there is a copay, which means they will still be draining

the money, we will still have an expensive service being provided, and the incentive, necessarily, to rein in costs by making the beneficiary pay may not always be there, if you have an uninformed beneficiary that is receiving that service.

Mr. SCANLON. There is also the issue that these beneficiaries are at a point where their illness prevents them, often, from expressing a judgment or making a judgment. In the case of people in skilled nursing facilities, we are talking about individuals that need daily skilled care, so they are quite sick and may not be able to have the information to make a decision.

In the case of home health——

Mr. BECERRA. It actually may increase the number of attorneys who are doing guardianships and all the other types of proceedings as well.

Mr. SCANLON. Right. In the case of home health, I would note that from our experience with long-term care, that long-term care involves assistance with the things that we normally take for granted to do ourselves—bathing and dressing, toileting and eating—and that people do not usually like to get assistance from others, particularly assistance from strangers in doing that.

And we have had experience with different demonstration programs where, when offered free services, people said no. But sometimes people's functional dependency is great, and their family's ability to provide assistance is limited, and therefore, people were willing to accept of more services. That is not to say every service is appropriate, but it is to suggest that people are somewhat selective about what services they want.

Mr. GROB. If I could add one other insight, I think the remarks I made about people not being quite sure what they are getting is because they do not have to pay for it. I do not want to predict how they would react, if they have to pay for it, but I do not think we could conclude that they would simply continue to take it, if they had to make a payment.

And an interesting thing here, we just mentioned, we were talking about home health in terms of beneficiary coinsurance. The strongest form of beneficiary coinsurance would be for them to have to pay after a certain point. The sickest patients we have here are those in SNFs, and in the Medicare SNF Program, we pay only for 100 days. So the program that takes care of the neediest patients does cut that benefit off after 100 days.

Mr. BECERRA. And I do not mean to imply that no one would want to be a good consumer, even if they are ill. It is just you have to be cautious in the way you proceed with that.

Mr. GROB. Exactly.

Mr. BECERRA. Let me ask a little bit about the whole issue of oversight. Do any of you know how much HCFA currently spends to provide the oversight of home health care SNFs?

Mr. GROB. I do not know the amount.

Mr. BECERRA. No idea?

Mr. GROB. I do not.

Mr. DOWDAL. Not for those services.

Mr. GROB. Not the amount.

Mr. DOWDAL. Their overall budget for safeguard activities for everything, including part A and part B, is like 400-plus million dollars, but that is only a small part of——

Mr. BECERRA. Out of a 260-some-odd billion dollar budget.

Mr. DOWDAL. The contractor budget is a little bit over $1.5 billion, so it is not a lot——

Mr. BECERRA. Any sense, since we do not have a number to give us a sense of what HCFA currently spends, of what it might take in the future if we try to corral these costs and come up with a system that might work, how much it might cost to provide the oversight?

Mr. DOWDAL. It would be very hard to estimate without knowing exactly what they were going to do, but if you look at when prospective payment was put in for hospitals, it gives you an idea of the kind of things that were required.

Congress specifically put into the law provisions to address each of the major concerns. For example, there was an incentive to increase admissions, so they required the PROs to look at admissions. There were quality concerns about prospective payment. There were specific provisions directed at that, and I think it was generally believed those provisions helped in keeping the prospective payment system in line.

I think the money spent on PROs, if you look at before and after, probably went up by about 50 percent.

Mr. BECERRA. Let me throw out an idea, not that I am proposing it, or suggest we go with it, just provoke some thought.

In the housing industry, we have used for a time a program, a tester program, where we have decoys go in and seek housing, public housing, and to find out if, in the private sector, there is any discrimination occurring against individuals who are seeking certain housing, not just the public housing stock, but just private housing as well.

Do you believe a tester program might have some use in this industry? And I do not mean—obviously, you cannot feign you are ill. If you need some assistance, it is going to be documented.

But perhaps have a system where, at some kind of random basis, we select certain individuals we will—if they agree—monitor closely the type of care they are being provided, so that rather than have a 100-percent oversight over each beneficiary's care, you provide a random selection process, so that you have some sense of what might be out there, generally.

Mr. SCANLON. Not just for these two benefits, but for oversight of all of Medicare's claims, we have been suggesting that there be a lot more attention devoted to targeting resources where there is going to be the largest return for their investment.

Mr. BECERRA. But specifically on a program of sorts, where what you do is you are actually, maybe not having a hidden camera there, but to some degree providing scrutiny over that particular care being provided to that individual, randomly selecting, for example, the beneficiary that will be watched with that beneficiary's permission, but to sense, on a random basis, what type of care is out there, rather than rely on 100 percent government oversight.

Mr. NEWHOUSE. Mr. Becerra, I certainly agree with your point that every—what I think is your point—every claim should face

some probability of audit, just as every tax return faces some probability, for purposes of trying to keep down the amount of fraud.

Whether it would be useful to have the kind of thing you suggest with decoys, I have not thought about before.

Mr. BECERRA. And it would not be decoys. I do not think you could feign that you are ill. You are either ill or you are not. But perhaps, beyond the audit, where you are looking at documents, and you can do a lot with documents, and it is difficult to really uncover the abuse that might occur, just strictly through documents; but actually have a system where you visually monitor, but randomly, because certainly, it would be very expensive to have someone watching particular beneficiaries and their care being provided.

Mr. DOWDAL. Medicare actually did do that for a period of time when they would go out and do medical reviews. They would take a random sample of beneficiaries at the agency and they would go out and visit them and see what was actually happening, what was going on in the house, go through the records very thoroughly, talk to the patient, things like that.

I believe that was considered to be fairly effective in identifying problems and holding down on problems. So basically, what you are talking about was at one time done. Now, they do virtually no on-site medical audits anymore.

Mr. BECERRA. You just said it was successful. Why is it no longer done?

Mr. DOWDAL. One of the reasons has been a decrease in the funds available for doing that kind of activity. They have to spread themselves thinner now because the amount of money has stayed kind of flat for a long period of time.

Mr. GROB. Let me just say that in the audits that I described earlier, the eight that we did, we did exactly that. We went out, we talked, we drew random samples of the beneficiaries. We went out and visited the beneficiaries, and if we could not visit the beneficiary we visited a representative.

We saw the conditions in which they were living, and we interviewed the physician of each and every one of them. And in the random samples we have now in the four States that I mentioned, we are repeating that. We have repeated that same process for those, and in the broad random sample we are taking in the Nation, we are doing the same thing.

We are drawing a random sample, actually talking to the people. Also, in terms of the selection of the groups that we went to see, these were selected on the basis of targeted type information. We thought either there was rapid growth or there were some other reasons. We thought maybe we should look at this one rather than some other one. It is expensive to do, but it is very effective.

Mr. BECERRA. I think it is cost effective, and if no one knows which coal was hot, you are going to try to walk very gingerly around all of the coals, and you will probably prevent a number of abuses from ever occurring.

Mr. Chairman, I have a couple of questions, but I am willing to wait, if there will be a second round.

Mrs. JOHNSON [presiding]. Thank you.

In the absence of the Chairman, I will continue as being next in line to question.

To follow on with the preceding gentleman's question, however, if you have done this kind of sampling in four districts, what has been your conclusion?

Mr. GROB. Our conclusion is that the amount of error made in making claims is much higher than we thought that it was when we started the process. As I mentioned, beginning in the eight audits we conducted in Florida, Pennsylvania, and California, the error rates varied between 19 and 64 percent of the services, and the error rates that we are finding in our random samples that are one in four States, in other words, nationwide—again, those are not done yet and I do not want to give numbers because of the quality control.

But as I said, the preliminary results we have now show error rates as high, if not higher, than the same preliminary results at that stage of these other audits.

Now, time has passed, so we think—remember that in the last 5 years the number of visits per beneficiary has more than doubled. OK. So that may account for the fact that we are seeing more errors now than we were seeing initially.

Mrs. JOHNSON. Are the errors primarily in terms of appropriateness of services, or in eligibility?

Mr. GROB. It is pretty much an even mix between the following things: Patients not being homebound, so in that case not eligible; services not rendered or documented; services not medically necessary; and then lack of a valid physician certification.

Mrs. JOHNSON. Thank you. That is very helpful.

I have a couple of questions I would like to pursue.

First of all, we certainly have known that we needed a better definition of homebound, and of visit for a long time.

Has HCFA made an effort to more clearly define those terms?

Mr. GROB. I believe that HCFA has proposed a refined definition of homebound in its fiscal year 1988 legislative proposals.

Mrs. JOHNSON. And not since then?

Mr. GROB. The proposal is on the table right now. I am sorry. I guess it would be——

Mrs. JOHNSON. You said 1988.

Mr. GROB. I meant 1998. I am awfully sorry. In other words, the proposals that they have just made, the President's——

Mrs. JOHNSON. To better define homebound?

Mr. GROB. 1998.

Mrs. JOHNSON. However, the court case was in 1989, and we have seen the volume escalate, dramatically, for a number of years now, and have they made any effort to define visit?

Mr. SCANLON. That effort is underway now in a research project in which they are studying the content and the time involved in visits, and they hope what will emerge from that is a way to classify visits.

Mrs. JOHNSON. Now, I just have to say, I think that is a shocking lack of leadership. We are really having a hard time dealing with the cost growth of home care services, and I did not realize—I just came from a hearing on the Oversight Subcommittee, and Medicare is one of GAO's high-risk areas—and to realize to what degree even

basic definitions have not been made to encourage effective monitoring of a program is really, frankly, scandalous, and discouraging.

Now, a second question I would like to ask, frankly, along that line.

We appropriated $800 million for expansion of our Inspector General capability in all of the States. It has been more than 6 months since we passed that money.

To what extent are those offices up and running, and to what extent have they set the priority, which seems pretty obvious, that home care services and proprietary agencies should be number one on the list?

Mr. GROB. Mrs. Johnson, I can address that.

We have undertaken, and are in the process, now, of filling all the positions that we can, given the money that was given to us to build it up. We are emphasizing the building up on the investigative side.

The amount we have this year will not be enough to cover every State this year, but we do have a plan as to when we will cover the States, and I can tell you, having come from the office there, we are very busy, indeed, hiring those people.

Here I am today to talk about home health. That certainly is among our highest priorities that we have. We have done numerous studies on this. In fact, I have in my office a collection I have made of all the studies we have done on this in recent years, including some recent ones which I would like to provide to the Subcommittee staff.

Mrs. JOHNSON. And to what extent do you set your priorities, and to what extent does HCFA drive your priorities?

Mr. GROB. We set our own priorities. In fact, we had set priorities related to home health, hospice, durable medical equipment, and nursing home services a couple of years ago, based on the trends that we saw, and we established what our priorities were in looking at those programs and designed all of the studies that led to this.

In fact, in the case of home health, we did a combination of these audits, that we are now seeing the results of here, which were carefully planned as part of a broad strategy. That is why they were in these different States. That is why we have the random draws.

And we simultaneously planned the kind of studies that look at the underlying structures, the surveys that we need to understand what is going on there. We did begin to coordinate all the different aspects—the investigative work, the audit work, the inspections work—into a whole system, so we could get a handle on the problem.

And some of the information we are providing in this testimony, and in these reports, is the result of that kind of intense priority setting and work.

Mrs. JOHNSON. We are thinking a lot about what data needs to be collected to better manage home health reimbursements, and while in a bill I introduced last year, we left it up to the Secretary, we are unlikely to do that this year because we know a lot more, and we think the thing will move forward more rapidly if we have better, clearer direction.

So I would be happy to have your input at a later date as to what data you think is important for us to collect.

Then, last, one of the things we have seen in managed care is a focus on the most common or costly diseases. I am not sure exactly what their criteria is. But on a few narrow diseases, to look at the outcomes research in order to do better case management, like asthma, and things like that.

So are there four or five most common diagnoses in the health care area?

Mr. GROB. I cannot speak to that.

Mrs. JOHNSON. Can anyone speak to that?

Mr. NEWHOUSE. You mean that account for disproportionate use of postacute care?

Mrs. JOHNSON. Yes.

Mr. NEWHOUSE. Yes, certainly, for example, hip fractures, strokes, would be two.

Mrs. JOHNSON. Would it make sense instead of—we all know the problems we are having with developing prospective payments, and also episode payments.

Would it make sense to take the three or four or five, or whatever it is, most common diagnoses, look at case management in them, and develop an episode payment immediately in those areas, and not try to do prospective payment and then episode payment, at least in those areas that drive the highest volume of visits?

Mr. SCANLON. One of the concerns in long-term care is that diagnosis often is a poor predictor of an individual's needs. As people age, they develop multiple diagnoses that interact, and then there are different severities of each of those diagnoses, and they combine to produce a functional dependency that really is the driving force behind need.

And it is the classifying of people by their functional dependencies, and then by the skilled services that may be associated with some of their diagnoses, that have been the primary means to try and identify what kinds of people we are trying to serve.

Case managers do focus on those elements, more than they do focus on diagnosis, and we may be able to make some progress in that area.

Mrs. JOHNSON. But if you draw this from the current criteria for homebound, plus a case management approach, which is really what we have done in the other areas, you would at least get a pretty good indicator, and I should think you could get that in the not too distant future, and then with an appeals process, or some other mechanism, to take into account complexity.

I am afraid we are waiting for the perfect, and while we are waiting for a good system, we are ignoring the extraordinary explosion of costs, or at least we are failing to take action in the way that will be effective, and yet there are some things we can think of to do that have worked in other areas of the health care system to control cost without doing everything at once.

Mr. SCANLON. We agree we do not need to wait for the perfect case mix system. What we can do is use the information we have available, now, along with concepts such as a case manager, and perhaps sharing the savings generated from the management of a case.

Those kinds of techniques combined with existing case mix methods could produce an acceptable prospective payment system for the future.

What we should do, though, is design prospective payment in a way that we will learn from it, so that we can modify it as we learn, rather than have a system that will be very difficult to change.

Mrs. JOHNSON. And is it your opinion we could do this, pass legislation this year?

Mr. SCANLON. I think we could.

Mrs. JOHNSON. I think it is really imperative.

Mr. NEWHOUSE. Mrs. Johnson, as I said before, we have proposed a demonstration project that would link acute and postacute benefits, and one way to get that off the ground would be to limit to a few diagnoses that linking, that were the high-use areas.

I might mention one other issue with a separate episode payment, which is for the people that use both an SNF and home health services. One has to confront the issue of are there two separate episode payments, since the same person could often go to either one, or conceivably both, quite appropriately.

Mrs. JOHNSON. And does your demonstration program proposal extend to enabling us to look at the use of Medicaid and Medicare resources for the same population at the State level?

Mr. NEWHOUSE. That would certainly be a more ambitious demonstration. We would be happy to think about that one, if you would like us to, but we did not get that ambitious, this round.

Mrs. JOHNSON. I would like any of you to help me think about that because there has been a lot of thought in New England about that and we are keenly interested in using those moneys to provide a more appropriate and commonsense continuum of care, without the regulations that govern placement here or there. So I would welcome your input on that.

Let me recognize Mr. Kleczka.

Mr. KLECZKA. Let me stay with home health care for a moment or two.

We have seen the rapid increase, Mr. Grob, on your chart here. Has anyone done a study of a subsegment of people receiving home health services, and related that to, let us say this same population was in a skilled nursing facility. For years we have been told that we save money by keeping people in their home environment, by having a nurse come in, a nurse assistant, whatever.

Has anyone compared a small segment of the current home health population, what that would be costing the program if they were in fact in a skilled nursing facility?

Mr. GROB. We have not done that.

Mr. KLECZKA. I am sorry?

Mr. GROB. We have not done that.

Mr. KLECZKA. OK. Well, do not you think that would be a logical thing to do?

Mr. GROB. It is a good issue, I think.

Mr. KLECZKA. OK.

Dr. Newhouse.

Mr. NEWHOUSE. I am sorry. Could you repeat that.

Mr. KLECZKA. Oh, I thought you were ready to respond.

Mr. SCANLON. There has been a number——

Mr. KLECZKA. Is what we were told for years and years a myth, that it is not cheaper to keep someone in their home? And I think before we sit here and decry the costs of home health care rising at a dramatic rate, we have to recognize that we have an aging population that is living longer, so that is definitely part of the increased cost.

But is it in fact false, that it is cheaper to keep somebody in their home with services coming in versus putting these people in a skilled nursing facility?

Mr. SCANLON. The reality of whether it is less expensive to keep someone at home is in part contingent upon the role of the family, because individuals at home rely very heavily on their families for an incredible amount of support.

When one is in a skilled facility, there is reliance completely on the facility for all the services that one needs. We do not attempt to deliver into the home formal services to substitute for all the care that one needs, only to supplement the role of the family.

And it is often the lack of a family that leads people to enter an institution.

Mr. KLECZKA. So is it your view that if we had no provision for home health services today, that we, in fact, would be spending more money because these people would then be in a nursing home?

Mr. SCANLON. One of our realities is that we have had very strong limits on the number of nursing home beds in this country and they have generally been quite full. We have recently seen a slight dip in the occupancy rates. But it is more likely that if we do not provide these services through the Medicare Program, that there will be more reliance on families than there is today.

Mr. NEWHOUSE. I think it is also hard to give an answer because it depends on the intensity of the services. For somebody that is getting a service every day, it is probably cheaper to have them in the nursing home, and for somebody that is getting one or two services a week, it is cheaper to have them at home.

Mr. KLECZKA. Yes, but I would think that some study along the way, comparing a small subset of this group, and what we are spending today on home health care, if in fact they were not in home health care, they were in a skilled nursing facility, what would that cost the taxpayers?

And I would think that would be an enlightening exercise, to say the least. Maybe you guys can talk about it, or we can provide for something in this Subcommittee here.

Let me move to the skilled nursing facilities.

Mr. Scanlon, in December 1996 the GAO issued a report on SNF routine cost limits, and at that point you reported that the number of SNFs granted exceptions to the limit increased from 62 in 1992 to some 552 in 1995.

What accounts for this growth, and could you give the Subcommittee some feel as to how the exceptions are given for—what is the rationale for the exceptions being granted.

Mr. SCANLON. We were quite concerned about the adequacy of information that was being required by HCFA in terms of a facility justifying that it was entitled to an exception.

The three kinds of information that HCFA is looking at are the length of stay for the individuals, the amount of ancillary services that are being received, and the share of Medicare patients in a facility.

Really, that last variable is the driving force behind these exceptions, and a facility that has more Medicare beneficiaries, it is going to have more ancillary services, and those are the two things the intermediaries look at most in granting these exceptions.

The fact that the routine cost limits have been frozen for a 2-year period probably has been a factor in motivating SNFs to apply for an exception to the limit, and knowing the intermediaries are not giving them adequate review, they are receiving those exceptions and it is costing the program money.

Mr. KLECZKA. OK. Anyone else want to respond to that?

Thank you very much.

Mrs. JOHNSON. Mr. Lewis, would you like to inquire?

Mr. LEWIS. Thank you very much, Madam Chair.

Madam Chair, I am sorry that I missed the testimony but I have copies of the testimony. You may be interested in knowing that I was away, speaking to a large group of Federal employees, about the importance of public service. So, I was doing the Lord's work, I think.

Let me just raise the question, both the administration and the home health industry have proposed a prospective payment system.

Are any of you familiar with these proposals?

Could you comment on them—the strength and weakness of each.

Mr. GROB. Mr. Lewis, I am familiar with the administration's proposal, but only today saw the proposal by the Home Care Association.

Mr. LEWIS. Let me hear what you think of the administration's proposal, and maybe other of your colleagues will have something to say about the industry proposal.

Mr. GROB. We are certainly supportive of any proposal to move to a prospective payment system, and the proposal of the administration is probably as good as any that we may have.

The one concern we have for it is to make sure that a stronger control over the costs occurs between the period in which the system is proposed and the time that it actually takes place. We are just a little worried about the passage of time—costs going up in the meantime.

Some of the information about the administration's proposal remains to be developed. In terms of the relative elements that represent a good design for a perspective payment system, I think the concept of sharing savings between the program and the agency gives agencies an incentive to be efficient as well as gives them the incentive to maintain services to the beneficiaries.

I think it is important we think about basing those savings on the differences between revenues and the costs incurred by the agency, at least, initially because at this point, as we have talked about today, we do not understand what constitutes a visit in home health. One of the critical elements in the industry proposal is to use the visit as a standard by which to base payment.

Thank you.

Mr. NEWHOUSE. One of my concerns would be the lack of a good case mix adjuster and the incentive, therefore, to bring in relatively light users to bring the average intensity down under our current relative inability to do case mix adjustment.

Mr. LEWIS. Would others care to respond?

[No response.]

Mr. LEWIS. Let me ask you, What information would be useful to collect about home health and skilled nursing care that we do not currently collect?

Mr. NEWHOUSE. On skilled nursing, we would like the application of procedure coding. That is addressed in my testimony, uniform coding of services so we know what is delivered. Similarly, as has been alluded to earlier, we would like a coding system for home health that reflected the resources that were used in the visit, something analogous to what we do on the per-physician visits in Medicare.

Mr. SCANLON. I think one of the areas we all are hopeful of developing further is the issue of outcomes with respect to both of these services. One of the things we have done in the past was to focus on very optimistic outcomes, such as improvement in functioning and recovery, that often do not happen for individuals with multiple diagnoses and at very advanced ages.

Therefore, I think we need to be able to be realistic about what outcomes should be attainable and then be able to measure some of those outcomes. It has been a challenge for the field of researchers in long-term care for years, one that we have not yet succeeded in developing an appropriate set of measures for us to be collecting.

Mr. LEWIS. I understand there was some discussion about people leaving managed care and going to fee-for-service, because fee-for-service pays for more services. In that same vein, have you done any studies that show people are leaving the Visiting Nurses Association to go to for-profits?

Mr. DOWDAL. We were told when we did our report 1 year ago by a number of people that that was the case.

Mr. LEWIS. You said you were told?

Mr. DOWDAL. Yes, but we did not actually go out and prove it. We were also told that the nonprofit agencies were increasing the number of services they provided in order to compete with the proprietary agencies.

Mr. LEWIS. Anyone else care to respond?

This is what you were told, but you do not have any study or any data?

Mr. DOWDAL. We did not specifically go on and look at that issue.

Mr. LEWIS. Do you think that is something that maybe you should take a look at?

Mr. GROB. The difference between the proprietary and the for-profits?

Mr. LEWIS. Between the proprietary and the nonprofit.

Mr. DOWDAL. We did have a lot of information in our 1996 report, which we can give you a copy of, that specifically relates to the differences between the various types of ownership. So, we did look at that.

The question about whether one ownership type was responding to the other, that is what I was saying we were told they were

doing. We did not actually do any work to prove it one way or the other.

Mr. GROB. Mr. Lewis, I will give you an impression. Just looking at Federal——

Mr. LEWIS. Yes, I would like to hear. I have gone out and visited many sites in my own district in Georgia.

Mr. GROB [continuing]. Just from looking at Federal programs on many different subjects for many different years, I would say, first of all, on home health, our reports certainly indicate that it is the proprietary home health agencies that are giving by far the greater number of services. I am not certain at all that I would want to advocate any kind of different policies applying to either the for-profit or the not-for-profit businesses.

I think as a general rule, the minute we begin making distinctions between those two in terms of Federal pay, we introduce—we make assumptions about incentives that are not really very practical. It is not true, for example, as a general rule, that for-profit enterprises are more expensive than not-for-profit enterprises. The incentive to make a profit can often keep costs down and can be competitive.

So, I only make that remark based not on the examination of the home health industry as such, but just over many years of looking at different programs. I do not really see a reason to want to limit the providers to only the nonprofits, for example, or to put stricter rules on the for-profits.

I think it is the basic program structure—in this case, the number of visits that we allow per beneficiary and this kind of thing that I would focus on. That is just an opinion.

Mr. LEWIS. Thank you very much.

Thank you, Madam Chair.

Mrs. JOHNSON. Mr. Scanlon, just to follow up on something you said in response to Mr. Lewis' question, comparing and contrasting the administration's proposal and the industry's proposal. Is the administration's proposal as detailed as the home health care industry's proposal is?

Mr. SCANLON. No, it is not.

Mrs. JOHNSON. The industry's proposal has a very interesting proponent that encourages savings by sharing those savings. It also has a provision for dealing with outliers or people who cost over the average, to prevent, to eliminate the incentive to cream. Do you think that will work?

Mr. Newhouse, since you clearly do not think that will work, I would like for you both to comment on that.

Mr. SCANLON. I think those kinds of features are the types of additions to a basic system one needs when you do not have the quality case mix adjuster and predictor that you would like to have. Now, the issue is in the details of how one goes about those mechanisms. How one complements the payment system with a review system for the appropriateness of a new case or a continuing case, I think both of those things are essential. I think they deal with some of Dr. Newhouse's concerns.

Again, our claims review ability is not perfect either. We need to recognize that.

The aspects of the industry's proposed system that you are identifying are things that are used for other kinds of services as well. A number of State Medicaid Programs, in terms of how they pay home health agencies and how they pay nursing homes, have adopted those kinds of features, precisely to encourage efficiency, while maintaining access and maintaining an incentive to preserve the quality of services. I think they are to be recommended for inclusion in the home health payment system as well.

Mrs. JOHNSON. Thank you.

Dr. Newhouse.

Mr. NEWHOUSE. Mrs. Johnson, you misread me. My testimony actually suggests an outlier system. I mentioned before, in response to Mr. McCrery, one of my concerns about a pure episode system would be at the high end. The payment for any additional visit might be zero for people who really needed 250 visits a year. They may not get them.

Whereas, an outlier system would leave some payment. I have in mind something like the PPS outlier system that, once you cross the threshold, you would still get some payment. Payment would not drop to zero for additional services.

Mrs. JOHNSON. Your comment I was referring to seemed to suggest that the industry's proposal would encourage savings, would provide such motivation to reduce costs that it could deprive service. I wanted you to discuss that a little further.

Mr. NEWHOUSE. No, my comment was really at the other end. Let me clarify two things.

Mrs. JOHNSON. OK.

Mr. NEWHOUSE. For the high user, my concern is what I just said. I am personally more comfortable with some payment rather than no payment. My comment in response to the earlier question was a concern there would be more light-intensity users under this proposal. If I am going to pay a fixed amount per episode, setting aside the outlier question, then I have an incentive to deliver services potentially to people who are not getting them now.

Insofar as there is an average, some kind of average number of visits that is being used as a threshold, I can, in effect, bring down the average by including some light users. I have concerns at both ends of the spectrum. The outlier scheme does help with respect to the high end.

Mrs. JOHNSON. Will the administration's proposal to move part of home health care reimbursement from part A to part B save any money?

Mr. NEWHOUSE. My understanding of the proposal is that it would leave the incentives to both the beneficiaries and the industry unchanged. So, I do not see where——

Mrs. JOHNSON. It does not save any money.

Mr. NEWHOUSE. It would not.

Mrs. JOHNSON. Would it cost money?

Mr. NEWHOUSE. It saves—well, obviously, it would save the trust fund money, because it would shift trust fund moneys to part B. In terms of overall government budgeting, I do not think it would save any money.

Mrs. JOHNSON. Would it cost money? Now, you would be making payments under two different systems. Would you weaken your

ability in the future to have a well-organized, integrated payment system? You would have the fiscal intermediary reimbursing for some things and other people reimbursing for other things.

Mr. DOWDAL. Under the current system, both A and B do cover home health care.

Mrs. JOHNSON. Excuse me?

Mr. DOWDAL. Parts A and B cover home health care now, but intermediaries pay all the claims. I would expect that if you did shift funding to part B, the intermediaries would continue to pay all of the claims.

Mrs. JOHNSON. So, you would expect there would be no increase in administrative costs and no greater problem with complexity?

Mr. DOWDAL. There should not be any big increase in either one of those areas, right.

Mrs. JOHNSON. Thank you.

Mr. Stark, did you want to comment?

Mr. STARK. If I may, Madam Chairman.

Your chart 6 is an annual compilation?

Mr. NEWHOUSE. Yes.

Mr. STARK. In other words, when you say number of visits per user, that could be per year?

Mr. NEWHOUSE. That is for fiscal 1994.

Mr. STARK. Yes, OK. It is a year?

Mr. NEWHOUSE. Yes.

Mr. STARK. For that big chunk in the 150-plus, with 275 average visits and $60-odd cost per visit, we are about $17,000 per year for that group of people, which is a lot of money. My question is, would any of you have any idea how this breaks down across the income spectrum? Is the care equally distributed among income groups or is there some kind of—

Mr. NEWHOUSE. I think what my recollection is that I have not seen a break by income, but these would be disproportionately people over 85 and insofar as their incomes are lower, that would be reflected.

Mr. STARK. It may vary from county to county, but in the counties I represent, when a senior is going into the Medicaid system, there is in fact a social worker or a case manager, whatever, who makes a determination of what the citizen needs. They take into account relatives that live in the area and the conditions of the housing that they live in and whether somebody else lives there and a host of things. Then they come up with, I suppose, a plan that determines if they need so many hours a week of assistance.

We have nothing like that in the Medicare Program, do we?

Mr. SCANLON. We do not have an independent person doing that, but we have the home health agency doing it and the agency is getting positioned to get its plan of care approved. So, that is meant to be the equivalent but there are differences.

Mr. STARK. No, these people are independent of the providers and I think for us to trust it, it would have to be that.

Then there is the issue of when someone graduates into full-time nursing. If not skilled, if it is only one or two ADLs and not other skilled services, they might very well, if they are low income, go into a nursing home, in which case, this would not apply; is that correct? I guess what I am exploring here are two avenues.

Would we benefit from any closer coordination with Medicaid? We keep wanting to hook this up to the acute care experience. Maybe we ought to look to the other end of the care episode and see how many of these people mature into a nursing home? That comes out of a different pot. It still costs the government some money, but we have battled with SNF fraud and abuse and we have managed that somewhat more than we have this.

The other question is, whether or not there is in fact a way to capitate this beyond just managed care for an incentive to cut back. If you have basically said that you have a population of people and you are responsible for making sure they are well fed, clean, hygienically served, bathed and dressed, basically your job is to be responsible for them, we could check that. We could pop in and visit the people whether you are there or not and see whether they are well fed, toileted, bathed, dressed.

I am asking, in those two areas, Has anybody ever looked at the idea of capitating this one way or another and/or hooking it up with Medicaid? That is the end of my question. It is pretty broad range.

Mr. GROB. Some of the studies we have done about people in nursing homes reach some of the things you are talking about. First of all, in the case of the staff, I remarked earlier that one of the problems we are seeing is the migration of some of the daily care expenses into the part B payment, particularly for incontinence care, wound care, and enteral nutrition—things which you would think would be a part of the daily care that someone would receive in a nursing home on the assumption that people go to nursing homes because they have problems like that. That seems to be related to daily care.

Now, no one is violating the law here at all. The law is very clear. If you have a resident of a nursing home, whether that person is residing in a Medicare part A paid SNF stay, or if they are staying in a nursing home under Medicaid funding or even under private pay—if they are over 65 and they are eligible for Medicare, then they are eligible for all services provided under part B of the Medicare Program. So, such a patient would be eligible for payment for enteral nutrition and wound care and other things like that, and it is perfectly legitimate for the providers to provide the services and bill Medicare for it.

Many States actually have policies that, in the case of any patient they have in a Medicaid nursing home who is on Medicare, they will in fact mail that bill to Medicare, and it is completely legitimate as far as the law is concerned.

Mr. STARK. We have been double dipping?

Mr. GROB. It is hard to say it is double dipping. They can get a higher amount if they go to the Medicare Part B Program than in the others, because those expenses ordinarily would be paid under a per diem rate which is limited in the SNF, and the States usually have limits as well on what they pay for per diem rates for the nursing homes. I do not want to say that it is illegal. It is completely legal and perhaps many people think it is appropriate.

What we have been advocating and the remarks I made at the end of my presentation on the proposal for prospective payment, is to make sure that any proposal specifies in great detail or, at least

in sufficient detail, what will be included in the prospective payment. If that specification is not made, those services will still migrate out and we will be paying for continually rising costs under the part B program.

One thing we have not said before, but since you have raised it, I will take the opportunity to say it. Our proposals have reached not just to the stay in the Medicare part A SNF but all the stays in the Medicaid area as well, because those patients are eligible for those Medicare payments.

Mr. SCANLON. I would also note that the Medicaid Programs are interested in coordinating with Medicare, although Medicare, I think, is not as well aware of the coordination that is underway. A number of the States have found it is a successful strategy in terms of trying to reduce their long-term care costs to not have as many nursing homes beds. Many States have even had moratoria for years, if not more than a decade, in terms of new construction of nursing homes.

They have, instead, put money into home care, where they have found that, spending about $5,000 a year, they are able to keep an individual in the community. In part, that depends upon the availability of family, but it also depends upon the willingness of Medicare to pay for some of the home care benefits. States are very knowledgeable about the fact that Medicare home care is available, as well as Medicare skilled nursing facility care, to cover some——

Mr. STARK. We are picking up some of the State Medicaid load in Medicare?

Mr. SCANLON. Medicare is the primary payer. So, the States feel that what they are doing is letting the beneficiary take advantage of the benefits they are entitled to.

Mr. STARK. Makes sense.

Thank you.

Mrs. JOHNSON. I would like to go on to the next panel, but as you leave, I would like to ask you to get back to us on how you would define visit and what changes you would make in homebound.

The other thing I would like for you to get back to us on is, Is there anything we can learn from the regulations before the court case that did manage to keep home care steady, that we should be looking at as we look to the future? Is there any portion of those regulations that we should be bringing forward as we think about it, how to do this in the future?

Thank you very much for your comments and your assistance. We look forward to working with you over the next few months as we get legislation together in this area.

[The following was subsequently received. A response from Mr. Newhouse was not available at the time of printing.]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAR 21 1997

The Honorable Nancy L. Johnson
House of Representatives
Washington, D.C. 20515

Dear Ms. Johnson:

In the question and answer portion of my testimony at the March 4 hearing of the House Ways and Means Health Subcommittee, you asked the panelists to provide answers to several questions that could be important in the design of a prospective payment system, or other control system, for Medicare's home health benefit. I am pleased to provide the following information in response.

Diagnoses

QUESTION: What are the most common diagnoses of home care patients? Would it be practical to develop a permanent or interim payment system that would authorize a certain number of visits for patients with particular diagnoses, allowing the home health agency to request additional payments for a beneficiary under rare circumstances when the need for additional care can be justified?

ANSWER: Enclosed are three tables from our July 1995 report on the Medicare home health program which list the 15 most common primary diagnostic codes used in 1993. These diagnoses account for 52 percent of all Medicare home health expenditures during that year. The tables also show the average total amount spent for each episode of care per diagnosis, the average number of visits per episode, and the average cost per visit for each code. The tables also compare these factors for low, medium, high, and very high cost home health agencies. This comparison might be helpful in determining what kind of limit--in terms of dollars or number of visits--might be appropriate if a payment system were to be developed for the most common diagnoses.

I have also enclosed a complete copy of the report from which these tables are taken. This may provide a context for interpreting the tables and other information that may be useful in developing the kind of payment system you describe.
[The full report is being held in the Committee files.]

Data Needs

QUESTION: What additional data needs to be collected to monitor the Medicare home health program?

ANSWER: It would be useful to have information about outcomes of care, particularly if a prospective payment system were developed. We recognize, however, that considerable research and experimentation might be needed to develop good outcome measures. We understand that the Health Care Financing Administration (HCFA) has undertaken such an effort. The HCFA has undertaken such an effort through the development of the Standardized Outcome and Assessment Information Set for Home Health Care (OASIS) project.

Definition of "Homebound"

QUESTION: What changes would you suggest be made to the definition of "homebound?"

ANSWER: We have found that the problems with the current definition of "homebound" are its enforcement as well as its content. The Office of the Inspector General has focused on the enforcement, and we will defer to HCFA regarding the definition itself. The President's 1998 budget includes a specific proposal.

Some physicians we interviewed about patients they had incorrectly certified for Medicare home health care said that they were unaware of the homebound requirement, or acknowledged they did not personally examine the patient to determine whether the patient was homebound. They often relied on advice from the home health agency when they signed the plans of care used to certify eligibility for home health. Therefore, we recommend that the law be modified to require that the physician who is treating the patient personally examine the patient before certifying a homebound condition and that this examination be repeated every 60 days before continuing care is authorized.

Definition of "Visit"

QUESTION: How would you define "visit" in a prospective payment system?

ANSWER: We strongly recommend against using "visit" as the unit of care in a prospective payment system. If a flat payment were made per visit, the incentive would exist for home health agencies to maximize the number of visits per episode of care. In essence, that is exactly the situation we have now. Medicare imposes a limit on the cost per visit, and most home health agencies' charges are made at that limit. We found almost no variation in the average charge per visit in our study. The number of visits caused the extreme variation in cost.

Nevertheless, if it were decided that a prospective payment system were to be based on a payment per visit, we would recommend refining the current system which distinguishes visits along the following lines: skilled nursing, physical therapy, occupational therapy, speech pathology, social services, and home health aides. A demonstration conducted by HCFA (completed in 1994) indicated that a per visit prospective payment had no effect on the cost per visit or number of visits. Perhaps a limit could be placed on the number of visits by type for different diagnoses--a refinement of the idea of a diagnosis based payment system discussed above.

I have enclosed a table from our July 1995 report on the type of service provided. It shows that lower cost home health agencies used proportionately more skilled care, whereas the higher cost agencies used proportionally more home health aides in caring for their patients. This shows that a limit on certain types of visits--primarily home health aides--might reduce home health costs.

Duggan v. Bowen Court Case

QUESTION: What controls were in place on the home health benefit before the Duggan v. Bowen court case? What lessons can we learn from this?

ANSWER: The previous requirements for receiving home health benefits included a 3-day prior hospital stay, a Part A copayment, a $100 deductible, and a limit of 100 visits per year. These provisions were eliminated by legislation enacted in 1972 and 1980.

Significant changes occurred in 1989, when clarifications were made to the home health coverage guidelines to settle the court case, Duggan v. Bowen. The lawsuit that was filed alleged that HCFA's definition of "part-time and intermittent" was not supported by the statute, which required "part-time or intermittent" care. This decision relaxed limitations on providing multiple visits per day and allowed payment for chronic conditions. The HCFA revised the coverage sections of the Medicare Home Health Agency and Intermediary Manuals.

The effect of both the legislative changes and those made in the wake of the court case has been to make home health care available to more beneficiaries for longer periods of time. This opened the door to significant increases in utilization and expenditures for Medicare home health services.

I hope this information is useful to you. We would be pleased to answer any other questions you may have.

Sincerely,

George Grob

George Grob
Deputy Inspector General
for Evaluation and Inspections

Enclosure

cc:

William M. Thomas
Chairman, Health Subcommittee
House Ways and Means Committee

AVERAGE MEDICARE REIMBURSEMENT PER BENEFICIARY INCREASED GREATLY FROM THE LOWER GROUP AGENCIES TO THE HIGHER GROUP AGENCIES WITHIN EACH DIAGNOSTIC CODE

We arrayed all diagnostic codes by total reimbursement by the Medicare program to the 6,803 HHAs in our inspection. The following table shows the 15 diagnostic codes with the highest reimbursement amounts representing 52.4 percent of total Medicare expenditures for home health in calendar year 1993.

ANALYSIS OF TOP FIFTEEN DIAGNOSTIC CODES
Groups Arrayed by Average Reimbursement Per Beneficiary

ICD-9-CM Diagnostic Code	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Total Average
			High-1	High-2	
Diabetes Mellitus	$1,575	$2,752	$4,988	$8,386	$3,652
Heart Failure	$1,423	$2,172	$3,380	$6,047	$2,537
Chronic Ulcer of Skin	$2,714	$4,145	$5,981	$8,908	$4,610
Cerebrovascular Disease	$1,946	$2,798	$3,916	$5,831	$3,049
Hypertension	$1,177	$1,860	$2,959	$5,071	$2,513
Pulmonary Disease	$1,474	$2,215	$3,327	$5,103	$2,498
Osteoarthrosis	$1,027	$1,509	$2,273	$3,979	$1,692
Urinary System Symptoms	$2,461	$3,473	$4,815	$7,156	$3,685
Fracture of Neck of Femur	$1,327	$1,946	$2,691	$3,935	$2,056
Cardiac Dysrhythmias	$1,124	$1,723	$2,689	$4,352	$2,055
Other Urinary Tract Disorders	$1,486	$2,062	$3,001	$4,765	$2,501
General Symptoms	$1,224	$1,983	$3,035	$5,108	$2,287
Osteoporosis	$1,882	$2,984	$4,124	$7,083	$3,035
Other Forms of Heart Disease	$1,069	$1,558	$2,560	$4,710	$1,834
Pneumonia	$1,045	$1,523	$2,152	$3,045	$1,629

Even when adjusting for size of the HHA, such differences remain. For example, we analyzed patterns of payment for the three principal diagnoses which accounted for almost one quarter of all 1993 Medicare expenditures, diabetes, heart failure, and skin ulcers, concentrating only on large HHAs (those with at least 1,000 beneficiaries). These results were consistent with those shown on the previous page. Using the principal diagnosis of diabetes we found that large HHAs with over $5,000 average reimbursement per beneficiary were reimbursed an average of $7,174; large HHAs with an average reimbursement per beneficiary of $3,000 to $5,000 were reimbursed an average of $4,433; large HHAs with an average reimbursement per beneficiary of $1,000 to $3,000 were reimbursed an average of $2,293; and all other large HHAs were reimbursed an average of $1,481.

AVERAGE REIMBURSEMENT PER VISIT IN EACH DIAGNOSTIC CODE DID NOT VARY MUCH AMONG THE FOUR GROUPS OF HHAs

When we analyzed the average reimbursement per visit in the top 15 diagnostic codes, we found little variation.

AVERAGE REIMBURSEMENT PER VISIT
PROVIDED BY HOME HEALTH AGENCIES
Groups Arrayed by Average Reimbursement Per Beneficiary

ICD-9-CM Diagnostic Code	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Total Average
			High-1	High-2	
Diabetes Mellitus	$52.29	$56.88	$57.51	$53.13	$56.16
Heart Failure	$55.39	$59.56	$55.26	$61.37	$57.33
Chronic Ulcer of Skin	$57.78	$64.02	$62.22	$58.65	$61.92
Cerebrovascular Disease	$56.07	$62.22	$60.20	$52.52	$59.66
Hypertension	$47.91	$52.55	$53.81	$55.65	$53.35
Pulmonary Disease	$54.79	$60.01	$58.42	$59.36	$58.50
Osteoarthrosis	$58.03	$64.62	$59.88	$56.72	$60.98
Urinary Systems Symptoms	$55.83	$61.19	$57.73	$60.44	$58.84
Fracture of Neck of Femur	$58.18	$65.34	$64.58	$52.06	$62.93
Cardiac Dysrhythmias	$55.35	$57.82	$57.01	$57.30	$57.11
Other Urinary Tract Disorders	$55.20	$58.79	$55.96	$57.19	$56.86
General Symptoms	$55.54	$59.25	$56.85	$56.57	$57.46
Osteoporosis	$56.21	$61.73	$59.68	$60.40	$60.05
Other Forms of Heart Disease	$56.62	$61.59	$58.83	$57.17	$59.29
Pneumonia	$58.26	$63.98	$61.31	$44.51	$60.38

THE NUMBER OF VISITS PER BENEFICIARY IN EACH DIAGNOSTIC CODE INCREASED GREATLY FROM THE LOW GROUP TO THE HIGHER GROUPS

We found that the average number of visits in the highest group HHAs was from 3 to 5 times greater than the average number of visits in the lower group agencies.

AVERAGE NUMBER OF VISITS PER BENEFICIARY PROVIDED BY HOME HEALTH AGENCIES
Groups Arrayed by Average Reimbursement Per Beneficiary

ICD-9-CM Diagnostic Code	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Total Average
			High-1	High-2	
Diabetes Mellitus	30	48	87	158	65
Heart Failure	26	37	61	99	44
Chronic Ulcer of Skin	47	65	96	152	75
Cerebrovascular Disease	35	45	65	111	51
Hypertension	25	35	55	91	47
Pulmonary Disease	27	37	57	86	43
Osteoarthrosis	18	23	38	70	28
Urinary Systems Symptoms	44	57	83	118	63
Fracture of Neck of Femur	23	30	42	76	33
Cardiac Dysrhythmias	20	30	47	76	36
Other Urinary Tract Disorders	27	35	54	83	44
General Symptoms	22	33	53	90	40
Osteoporosis	34	48	69	117	55
Other Forms of Heart Disease	19	25	43	82	31
Pneumonia	18	24	35	68	27

TYPE OF HHA VISIT

OVER HALF OF ALL VISITS PROVIDED BY HIGHER GROUP HHAs WERE HOME HEALTH AIDE VISITS

HHAs in the lower group provided nearly sixty percent of all their visits as skilled nursing and physical therapy visits while higher group agencies provided less than half of their visits in those categories.

TYPE OF VISIT PROVIDED BY HOME HEALTH AGENCIES TO MEDICARE BENEFICIARIES HHAs Arrayed into Four Groups Based on Their Average Medicare Reimbursement per Beneficiary					
Type of Visit Listed in Descending Order by Utilization	Lower Group HHAs	Middle Group HHAs	Higher Group HHAs		Total Average
			High-1	High-2	
	Percentage of Total Visits				
Home Health Aides	38.1%	42.6%	51.4%	55.1%	46.9%
Skilled Nursing	48.6%	44.8%	40.3%	37.7%	42.7%
Physical Therapy	10.2%	9.3%	6.1%	5.2%	7.7%
Occupational Therapy	1.4%	1.5%	0.8%	0.5%	1.1%
Speech Pathology	0.9%	0.7%	0.5%	0.5%	0.6%
Social Services	0.8%	1.1%	0.9%	1.0%	1.0%
TOTALS	100%	100%	100%	100%	100%

GAO Response to Request for Further Information from Representative Nancy Johnson

DEFINING VISIT AND HOMEBOUND

Because of the many differences among Medicare patients and their care needs, precisely defining what constitutes a home health visit is probably not feasible. Under Medicare's current cost-based payment method, a precise definition of visit is not essential because every visit, in effect, is paid at the home health agency's average cost, as long as that average cost does not exceed the agency's cost limit. Cost reimbursement gives agencies financial incentives to increase the number of visits to each patient above the level medically necessary and to increase the number of patients treated because both of these actions help maximize revenues. On the other hand, cost reimbursement does not give agencies incentives to hold down costs unless a particular agency's costs are near or above its cost limit. Also, cost reimbursement does not give agencies incentives to underserve patients because doing so would only decrease an agency's revenues.

As discussed in my statement, prospective payment for home health would reverse most, if not all, of the financial incentives of cost reimbursement, varying somewhat based on the unit of service chosen for payment purposes. Because it is so hard to define a visit, using the visit as the unit of service is probably not a good choice. This choice would give incentives to increase the number of visits furnished to each patient and at the same time to decrease the content of the visits. Moreover, because of the difficulty in defining a visit, it would be difficult to design a review system capable of identifying and controlling the effects of these financial incentives.

Thus, an episode of care, although also difficult to define, is probably a better choice for the unit of service under a home health care prospective payment system. The length of time covered by the episode is crucial; it should be of sufficient duration to cover the care received by most patients so that the benefits of the prospective payment system affect most of the services furnished.

Turning to the definition of homebound, the purpose of the homebound criteria is to assure that the patient is not able to get care in a less costly environment such as a physician's office therapy center. That is why over the years, the definition of home bound has emphasized such things as the inability to leave the home without substantial difficulty. The problems have arisen in the words used to convey the concepts and the interpretations of them. HCFA has proposed language designed to better quantify what home bound means and we would defer to HCFA at this time.

WHAT PARTS OF THE PRE-1989 GUIDELINES HELPED CONTROL UTILIZATION

Two of the most important changes to the guidelines that affected Medicare's ability to control the use of home health services involved in the definition of "part-time or intermittent care" and modifications to the intermediary medical necessity denial process. HCFA had required that services be both part-time and intermittent which was changed to part-time or intermittent. Under this change, 21 days of daily visits became allowable and some agencies then began to routinely furnish 3 weeks of daily visits to their patients and then decrease visit frequency. The changes in intermediary claims denial processes resulted in substantially more work required to develop denial cases. This factor combined with a decrease in funds for reviewing cases, led to significantly fewer denials. Our report, Medicare: Home Health Utilization Expands While Program Controls Deteriorate, GAO/HEHS–96–16, Mar. 27, 1996, discusses these matters in more detail.

Mrs. JOHNSON. The next panel will consist of Steve Chies, chairman of the American Health Care Associate Advocacy Committee, and owner/operator of North Cities Health Care Inc., at Coon Rapids, Minnesota; Joseph H. Hafkenschiel, president of the California Association for Health Services at Home, Sacramento, California; and Margret Cushman, president of VNA Health Care Inc., Plainville, Connecticut, on behalf of the National Association for Home Care.

A special greeting to Peg who has been enormously helpful to me over many years in understanding the issues involved in delivering high quality home care. Hers is one of the few agencies in the State that still delivers home care services to the most crime-ridden sections of Hartford, in spite of our unwillingness to recognize the cost of security necessary for that visiting nurse.

Peg, I have admired your determination to look at service need regardless of where it lies. We appreciate your good service and your leadership.

Ms. CUSHMAN. Thank you.

Mrs. JOHNSON. Steve Chies.

STATEMENT OF STEVEN CHIES, CHAIRMAN, AMERICAN HEALTH CARE ASSOCIATION ADVOCACY COMMITTEE; AND OWNER/OPERATOR, NORTH CITIES HEALTH CARE, INC., COON RAPIDS, MINNESOTA

Mr. CHIES. Thank you, Madam Chair.

I am Steve Chies. I am an owner/operator of North Cities Health Care, Inc., a provider of long-term care and SNF services in Coon Rapids, Minnesota, speaking on behalf of the American Health Care Association and our 50 affiliated associations, representing 11,000 long-term care providers, for-profit, not-for-profit, assisted living and nursing providers. We are providing care to a little over 1 million residents and citizens of this country.

Let me start by reiterating our support for the direction that last year's Balanced Budget Act took. We do support increasing choices for seniors, modernizing and transforming Medicare into more market-oriented systems, and moving SNF facilities toward an episodic prospective payment system. We look forward to working with you this year to not only ensure solvency of the Medicare Trust Fund, but to reform Medicare policies and create a more competitive care system.

Right up front, Madam Chair, I would like to respond to some of the discussion that took place on the earlier panel regarding the increase in cost of SNF payments over the last few years. The chart that was presented by the CRS last week detailing trends in the Medicare payments to SNF facilities probably does not portray an accurate direction that the SNF growth is going in.

We have provided in our testimony another chart which extends the growth in SNF coverages over the next few years. It looks to us like SNF growth is going to drop to about 10.6 percent next year and into the single digits by 1999. It looks like it will be under 7 percent by 2002 without any specific, intervening congressional action.

Later in my testimony, what I have provided you, I can detail why we think the growth in the SNF benefit under Medicare has been a beneficial benefit not only fair to the Federal Government, but also the recipients as well.

Since I only have a few minutes, I would like to highlight some of the areas that we, perhaps, agree and disagree on.

We were interested to listen to the previous panel talk about their support of prospective payment. We would also add our support to that discussion. We would support and have a long history of supporting a prospective payment system. We want to make sure

it includes dealing with some of the outlier issues and some of the case mix issues that have been discussed. It does make sense to move in that direction.

We would also support the across-the-board reduction in the baseline to obtain the necessary savings or to permanently capture the inflation stream from the over 96 routine cost limits. However, the caveat we would put on there is, we think the Congressional Budget Office behavioral offset should be reduced once all the SNF services are incorporated into a single payment stream.

We also support the consolidated billing for SNF services, to part A patients, although we would encourage a thorough legislative review of this and some discussion with providers before that is finally drafted into place.

There are a couple of other issues in the budget that we would like to chat about. One is, we do oppose the administration's attempt to repeal many of last year's fraud and abuse provisions, including the provision prohibiting the intentional transfer of wealth from wealthy individuals to qualify for Medicaid. We would support the extension of the PACE demonstration project. That is the program of all-inclusive care for the elderly. We would encourage the expansion of for-profit facilities, for-profit entities to participate in that program.

We also support the administration's nurse aide training proposal, to ensure training programs in rural areas, which are not jeopardized due to unrelated survey deficiencies.

We would oppose the imposition of the new user fees for the initial certification of Medicare for new facilities. We have a longstanding, continued support for the use of alternative accreditation organizations, such as JCAHO for SNF survey and certification.

Just to highlight a couple of key points, we are concerned over the level of reductions providers are being asked to participate in to shore up the Medicare Trust Fund. About 76 percent of our patients are funded by Medicaid, about 8 percent by Medicare. Our ability to pass these costs on to others without a reduction in quality would be extremely difficult, especially with the discussion and the repeal of the so-called Boren amendment.

Second, we would ask the Subcommittee and the staff to recognize the difference between a cost-based payment and—in the acute care DRG system which is a price-based system when allocating specific reductions. It is a different system.

Third, our analysis of the causes of the growth shows it has been largely stimulated by the hospital sector. In the last 10 years, the patients we have been receiving have been much sicker and we have received them much quicker than we have in the subsequent 10 years.

We would support a couple of pieces of legislation by Members of the Subcommittee, including Congressman Ensign's discussion of reducing or waiving the 3-day hospital stay for a certain subset of DRGs. We would also support Congressman Stark's legislation requiring consumer disclosure when hospitals move patients from acute care beds into a related SNF or home health care agency.

Madam Chair, we appreciate this opportunity and we look forward to the questions.

Thank you.

[The prepared statement and attachments follow:]

Statement of Steven Chies, Chairman, American Health Care Association Advocacy Committee; and Owner/Operator, North Cities Health Care, Inc., Coon Rapids, Minnesota

Mr. Chairman and Members of the Subcommittee, I am Steven Chies, an owner and operator of North Cities Health Care, a provider of long term care and skilled nursing facility (SNF) services in Coon Rapids, Minnesota. I am speaking today on behalf of the American Health Care Association, a federation of 50 affiliated associations representing over 11,000 non-profit and for-profit assisted living, nursing facility, and subacute providers nationally. On behalf of AHCA's members, and the one million plus residents of our member facilities, thank you for the opportunity to speak at this important hearing.

First let me reiterate our support for the direction of last year's Balanced Budget Act. We support increasing choices for seniors, modernizing and transforming Medicare into a more market-oriented system, and moving skilled nursing facilities toward an episodic Prospective Payment System. We look forward to working with you this year, not only to ensure the solvency of the Medicare Trust Fund, but to reform Medicare policies and create a more competitive and fair system.

Right up front, Mr. Chairman, I'd like to refer to the attached chart which was used last week to brief Members of the Subcommittee. Figure 3.18, Trend in Medicare Payments for Skilled Nursing Facility (SNF) Care, 1983–1996, no longer represents an accurate portrayal of SNF growth. In fact, the second chart using Congressional Budget Office (CBO) January 1997 baseline shows SNF growth dropping to 10.6% next year and into single digits in 1999. This trend-line drops to under 7% in 2002, without any intervening Congressional action.

More importantly, as I will explain later in my testimony, this growth is good for Medicare because it provides services in a quality, lower cost environment, and has allowed the acute care sector to dramatically reduce acute lengths of stay and increase efficiency. Our industry analysis indicates the boom in growth has subsided, so the dramatic chart prepared by CRS overstates the current growth factor and understates the reasoning behind it.

Since I only have five minutes, let me get right to the point of your hearing by first responding to the Administration's 1998 Budget and its proposals affecting SNFs.

• We support the Administration's case mix adjusted, per diem Prospective Payment System (PPS) proposal and are working with the Health Care Financing Administration (HCFA) on its development. While we have not seen the final language, and want to be sure it includes and outlier policy and that the case mix adjustment methodology covers the full range of SNF subacute services being provided in our facilities, HCFA's PPS is the only achievable and rational first step in obtaining the cost savings needed in Medicare at this time. Over time, moving to a more comprehensive, episodic system makes sense;

• We would support an across the board reduction in the baseline to obtain the necessary savings, or the permanent capture of the inflation stream from the OBRA '93 routine cost limit (RCL) freeze. However, we strongly believe that the Congressional Budget Office (CBO) "behavioral offset" should be reduced once all SNF services are incorporated in a single payment stream, minimizing the ability to "maximize" reimbursement. This should reduce the overall PPS rate reduction needed for Medicare savings;

• We cautiously support consolidated billing for all SNF services to Part A patients and are continuing internal discussions regarding consolidated billing to Medicare Part B patients. In addition to losing $400 million over the budget period, significant issues have not yet been addressed in any draft we have seen. We do not believe that HCFA or the Congress has fully explored the details or policy ramifications involved in exactly how such a system would work, and we encourage a thorough review of these issues with providers before the final legislative language is drafted,

In addition to these provisions directly affecting SNFs, we also wish to state our views on a few other proposals in the FY '98 Budget, including:

• We oppose the provision redefining discharges from Hospitals to PPS exempt entities and feel this will incentivize acute care providers to hold on to patients longer to obtain the full DRG payment and then move patients into related, exempt home care stays. The more appropriate solution to address the problems HCFA is concerned with is best summed up by Dr. Uwe Reinhart in a January 31, 1997 letter to AHCA's Executive Vice President Dr. Paul Willging, where he stated, " ... what is needed is a recalibration of the DRGs to reflect the modern potential of

subacute care, and then a system of open, competitive bids for Medicare's subacute care business, without any differential between hospitals and freestanding SNFs";

• We oppose the Administration's Respite Care provision unless nursing facilities are included in eligibility and we also wonder if a new and very limited benefit costing $1.8 billion is feasible at this time;

• We oppose any provider service organization (PSO) provision that does not ensure a level playing field for all providers and gives a competitive advantages to hospitals or physician networks;

• We oppose the Administration's attempt to repeal many of last year's fraud and abuse provisions including advisory opinions for providers, provider protections against unfair civil monetary penalty authority, and a provision prohibiting "intentional" transfers of wealth from wealthy individuals to qualify for Medicaid.

—While the latter provision was poorly drafted, rather than repeal, the mandatory purchase of long term care insurance should be required for individuals wishing to transfer significant assets out of their estates:

There are also several provisions in the Budget without cost implications which we would like to address. They include:

• We support the extension and the expansion of the Program of All-inclusive Care for the Elderly (PACE) demonstration, but believe critical improvements should be made in consultation with providers examining ways of expanding the program into a market driven system. The legislation should be expanded to allow for-profit entities to apply for waivers and enter the trial period for providing PACE services. There is no justification to allow only non-profits or public entities to participate;

• We strongly support the Administration's Nurse Aide Training proposal to ensure that training programs in rural areas are not jeopardized due to unrelated survey deficiencies. We encourage its immediate enactment;

• We oppose the imposition of new "user fees" for initial certifications under Medicare for new facilities and continue to support the use of HCFA regulated accreditation organizations, such as JCAHO, for SNF survey and certification. JCAHO is currently utilized for hospital certification, a much more complex facility than a nursing home, and using JCAHO for surveys under guidelines which are at least as stringent as HCFA's would save as much as $110 million per year;

• We support the collection of data for HCFA to explore developing an integrated post acute care payment system. However, we oppose granting the authority for the Secretary to implement any such system without Congressional oversight or approval. While we are the lower cost provider of post acute services and could benefit from such a system, preliminary research we have already undertaken shows the similarity of patients across sectors may not cover the entire spectrum of current post acute services.

These are our views on the Administration's Budget provisions and I will be glad to answer any questions you may have.

Let me also articulate four key points we would like to make sure you are aware of before you begin drafting reconciliation legislation.

First, we are concerned over the level of reductions providers in general are being asked to contribute to shoring up the Medicare Trust Fund. In the long term care field in particular, where 76% of our patients are funded by Medicaid (68%) or Medicare (8%), our ability to pass on these costs without a reduction in quality would be virtually impossible—especially in conjunction with repeal of the Boren Amendment.

Second, we ask the Subcommittee and staff to recognize the difference between a cost-based reimbursement system and a "profitable" acute care DRG system when allocating industry specific reductions. It is unfair for post acute care providers to be allocated similar spending reduction targets when our reimbursement system does not build in the significant profit margins which acute care providers currently are making.[1]

Third, as I stated earlier, post acute care has been singled out for "high rates of growth." Our analysis of the causes of the growth show it has been largely stimulated by the hospital sector. We have documented through HCFA data a 31% reduction in patient lengths of stay for the 62 most common Subacute care DRGs during the time period ProPAC singled out for high post acute growth.[2] This movement of patients "quicker and sicker" into SNFs and home care has driven spending growth on post acute care services. While the increased population accounts for a third of

[1] The Prospective Payment Commission reported 1/14/97 that the average PPS margin for all hospitals in 1995 was 7.9%.

[2] See attached chart developed through HCFA data published in the federal register.

this growth, the fact that patients are higher acuity, "sicker" patients require a higher level of spending on ancillary services and routine costs for patient needs.

Until a patient classification system is finished however, and applied to SNF patients, quantifying how much of an impact the higher acuity has on spending is difficult. We believe, however, that this factor is significant, and cannot be dismissed in assessing the reasons for spending growth.

In addition, much of the growth in SNF post-acute services can be attributed to the hospital-based SNF sector, and little has been done to quantify this factor. Hospital-based SNFs have been growing at a 200% rate vs. a 29% for freestanding SNFs.[3] Hospitals now account for over 17% of SNFs and 22% of home health agencies. In 1994, they accounted for 13.3% of SNF facilities, and yet received 30% of Medicare SNF payments. Clearly the hospital-based sector has been driving much of the growth in post acute care.

Finally, the promise of post acute care was not only intended to be quality, lower cost rehabilitation, but to achieve cost savings by substituting such care for more expensive acute care. While the substitution has taken place through the movement of patients into the lower cost setting, the hospital DRGs have not been adjusted accordingly. The Medicare program should benefit by sharing a portion of the efficiencies gained through the recalibration of the most common post acute care DRGs. The 31% reduction in patient lengths of stay should have garnered savings for Medicare as well as for hospitals, and the availability of post acute care allowed that efficiency to take place.

In the coming weeks, we look forward to working with you and commenting on these issues further. Of critical importance to the industry is the design of the new PPS. Unlike the acute DRG system, HCFA seems to be headed for a much quicker, 4-year transition period. The industry will need to analyze this impact quickly and report back to you, but thus far, we have little in the way of details. The treatment of capital and ancillary services during this time is of critical importance.

Mr. Chairman, and Members of the Subcommittee, we ask that you consider one final request. We are being asked to tighten our belts again; to become more efficient and to work within new limitations to help shore up the Medicare program. This, we are glad to do, and wish to work closely with you in ensuring this effort is fruitful and will ensure the continuation of high quality patient care within our facilities.

We urge you to review legislative initiatives that would not only reduce spending on services within our facilities but which would improve efficiencies, quality or patient care. Some of these initiatives include legislation introduced by Congressman Ensign and Ranking Minority Member Stark.

- We strongly support legislation introduced by Congressman Ensign in the 104th Congress to require the Secretary to waive the three-day hospital stay for a subset of DRGs the Secretary determines may save the program money by substituting lower cost SNF care for acute care. We urge you to forward this legislation to the Congressional Budget Office for scoring purposes and to include it in your package should it prove cost-worthy;
- We also urge you to support Congressman Stark's legislation requiring consumer disclosure when hospitals move patients from acute beds into related SNFs or home health agency settings. Most patients are not aware they have a choice of going to a lower cost provider outside of the hospital network.

Finally, Attachment 1 contains a comprehensive list of initiatives before your Subcommittee and the full Committee we believe are worthy of your consideration. We would like to work with you on them to improve the Medicare program, improve quality patient care, eliminate fraud and abuse and enact tax policies to stimulate market oriented approaches for long term care and competitive opportunities for long term care providers.

Thank you, Mr. Chairman, for inviting us to appear before you today. We look forward to working with you to see that a PPS for SNFs is implemented and that the post acute care continuum contributes to improving and shoring up the Medicare program in a fair and equitable manner.

---

[3] See attached chart developed from the ProPAC 1996 Annual Report to Congress.

ATTACHMENT 1

MEDICARE

• Oppose reductions that are unfairly allocated to Skilled Nursing Facilities (SNFs).

• Support a Prospective Payment System (PPS) for SNFs that is based on patient needs, not the site of service, and is facility specific and case-mix adjusted.

• Oppose reductions in the SNF Routine Cost Limits (RCL) during the development of a PPS, allowing for exceptions until PPS implementation.

• Recalibrate acute care DRGs to reflect reduced lengths of stay to achieve savings through the utilization of post acute care, and oppose barriers to the provision of subacute care, including proposals to bundle SNF payments through acute providers.

• Authorize and implement a Prospective Payment System for Skilled Nursing Facilities (SNFs) that is based on patient needs, not the site of service, and is facility specific and case-mix adjusted. Ensure the proper collection of data for timely implementation and possible transition to a system covering all SNF services.

• Protect SNF Routine Cost Limits from unwarranted reductions or freezes during the development of a PPS.

• Oppose efforts to unfairly limit reimbursement for the provision of ancillary services, including all therapy, laboratory and physician services in SNFs.

• Repeal the three-day hospital stay, or at the very least, require the Secretary to waive the 3-day hospital stay rule for a minimum of five DRGs to demonstrate savings in Medicare—H.R. 4244 (104th Congress) introduced by Senator Dick Durbin (D–IL).

• Preserve the atypical exceptions process or a similar process to ensure adequate reimbursement for higher acuity patients in SNFs.

• Modify the laws on swing beds and "short term transitional beds" in hospitals. More and more hospitals are using either swing beds or "short term transitional beds" to convert empty acute care beds to SNF beds, and particularly subacute units. The law governing swing beds and short term beds grant hospitals flexibility which NFs and SNFs don't have. Two specific goals which would address this are:

a. Require hospitals to obtain long term care CONs to convert these beds and preclude states from giving hospitals priority in this area by not allowing them to either: 1) allow conversion of acute beds to long term care beds without a CON or 2) create inventory measurement devices which exclude from the count existing SNF and NF beds resulting in large estimates of need which are inaccurate.

• Recalibrate the acute care DRGs involving post acute care to adjust them downward to reflect greatly reduced acute care length of stays.

• Ensure a level playing field for SNFs in any managed care legislation, including proposals to remove anti-trust barriers in hospital/physician provider service networks or restrict SNF access to ownership or participation.

• Eliminate the 3-year "new provider" exemption from the Routine Cost Limits.

• Require consolidated billing for all Part A Medicare services and require that copies of all Part B bills for services rendered in nursing facilities be provided to nursing facility operators.

• Support legislation introduced by Congressman Pete Stark to require hospitals to notify patients of competing opportunities in the area when patients are ready to move out of the acute care setting.

• Oppose efforts to further reduce reimbursement for capital costs and explore the possibility of modifying or repealing onerous DEFRA capital limits placed on SNFs in 1984.

• Reinstate the Medicare Waiver of Liability for SNFs, Hospice and Home Health—H.R. 3678 introduced by Congressmen Andy Jacobs (D–IN) and Rob Portman (R–OH).

• Defeat attempts to bundle post acute care payments through acute care providers.

• Ensure representation of long term or subacute care on ProPAC or any other oversight body or Commission established by Congress or the Administration.

• Monitor PACE, ON–LOK and Social Health Maintenance Organization legislation and ensure the fair participation of NF/SNF providers in these integrated programs.

Fraud and Abuse

• Clarify that existing physician self-referral laws (i.e. Stark legislation) do not apply to NFs and SNFs. A recent HCFA letter states for the first time that this law does apply to nursing facilities. We know that Congressman Stark, in proposing the legislation, stated that he did not intend to capture nursing facilities in the law. HCFA's interpretation would even prohibit certain referrals by a facility medical director to a facility which either provides or bills for PT, OT, DME and certain other listed services.

• Preserve the entire anti-fraud and abuse provisions enacted last year which strike a balance between providing education for consumers, providers and payers to prevent violations, while increasing tools for enforcement against willful and criminal violations of the law.

• Preserve and clarify the intent of provisions in the Kennedy/Kassenbaum insurance reform bill that make it a felony to knowingly and willfully dispose of assets to become eligible for Medicaid. The law appears to penalize only those persons and their counsel who attempt to transfer assets to qualify for Medicaid and don't' get it right, thus resulting in a period of ineligibility under state law. Everyone thinks this is a bizarre provision. The real goal should be a provision which penalizes those who get it right since they are the ones shielding assets form consideration in the Medicaid eligibility computations.

• Push for several modifications to existing fraud and abuse laws, including:

a. Remove from the law any language (and/or otherwise clarify that these arrangements are not "kickbacks) which precludes suppliers, especially labs and pharmacies, from offering certain free services (like employee screens or inservice training) as marketing tools to customers (NFs) who already use the company. The government has been construing these as inducements for referrals since the facility would otherwise have to pay for these things.

b. Preclude the OIG from looking behind transactions which otherwise meet an established fraud and abuse "safe harbor" to question the "intent" of the transaction and thereby declaring it illegal, despite its apparent compliance with a safe harbor.

c. Preclude the OIG from undermining the "employee exception." The OIG is proposing to remove this exception in cases where an employer requires an employee to refer clients or patients to the employer's facility.

d. Oppose strongly the administration's efforts to repeal the advisory opinion provision and the "risk-sharing" exception to the kickback laws enacted late this year. Clinton has pledged to try to repeal both.

Build upon last years legislation by enacting laws that better identify criminal activity and correct billing systems that allow fraud to exist.

Social Security

• Examine "privatization" alternatives to the current system to see if citizens can increase retirement savings without increased risk and obtain more protection against the expense of long term care.

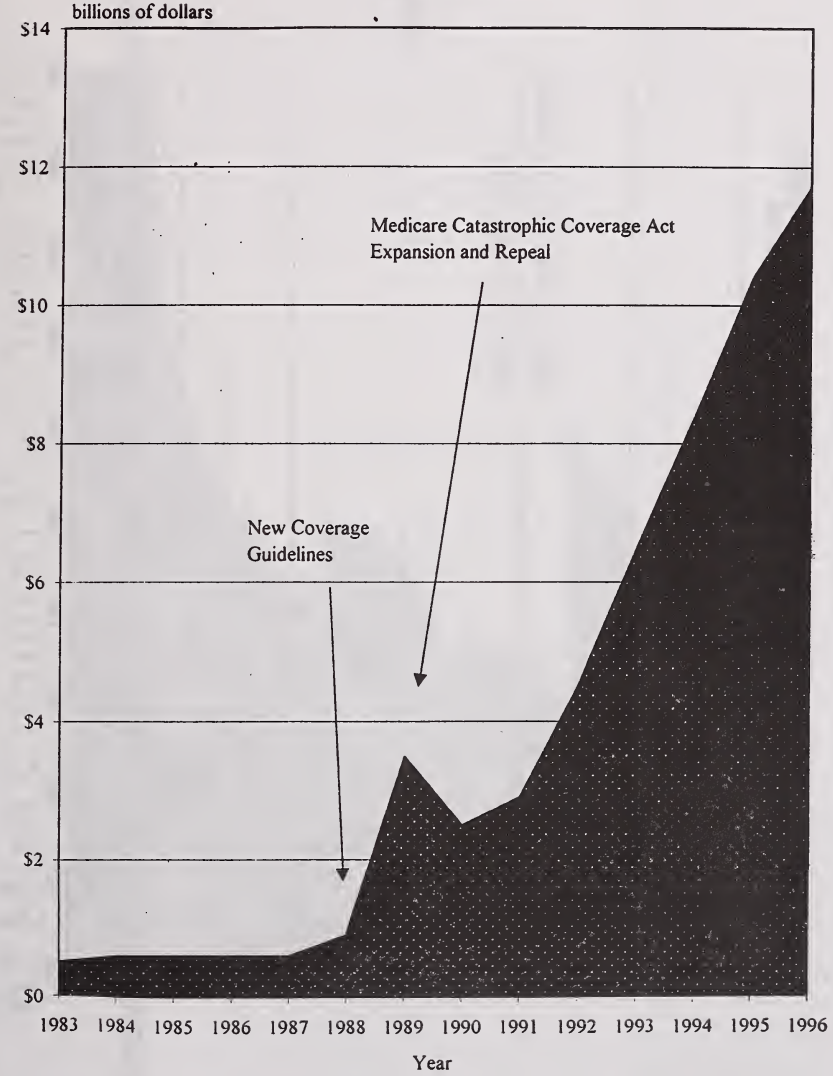
• Require that Social Security benefit applicants be informed that long term care is not covered by Medicare or any other federal program.

Taxes

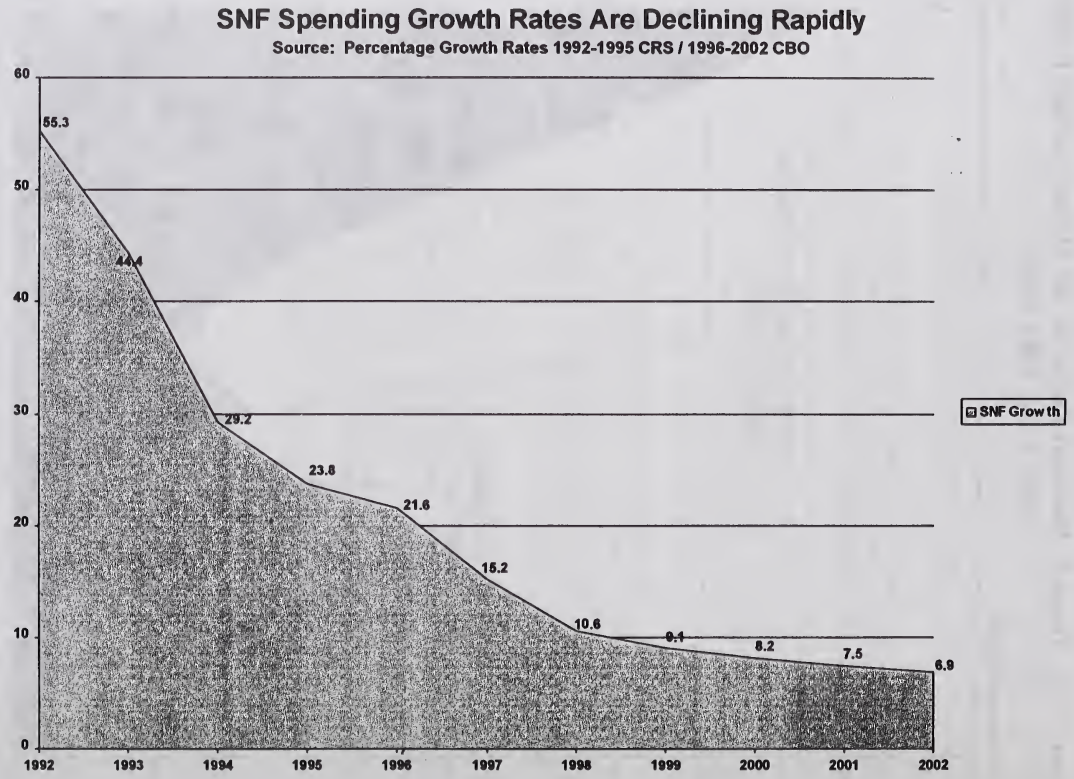
• Reauthorize, expand eligibility, and increase the percentage of the Work Opportunities Tax Credit (WOTC) and support the new Welfare to Work 50% tax credit in the Administration's budget.

• Modify the Clinton personal residence capital gains plan or current law to increase the one-time exclusion on the sale of a principle residence to $1,000,000 or $500,000 respectively from $125,000 for persons over 55 years of age, providing that they use proceeds from the additional tax-free funds to purchase long term care insurance, place adequate funds in trust for the sole purpose of providing long-term care, or to gain admission to, or on-going residence in a qualified nursing facility or Continuing Care Retirement Community.

Figure 3.18. Trend in Medicare Payments for Skilled Nursing Facility (SNF) Care, 1983-1996



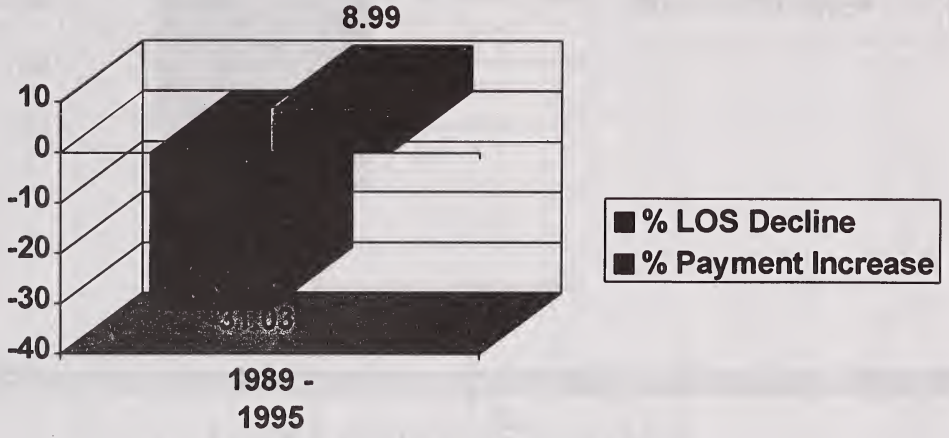
Source: Figure prepared by CRS based on data provided by HCFA, Office of the Actuary, and Prospective Payment Assessment Commission Report to Congress, June 1995 and June 1996.


SNF Spending Growth Rates Are Declining Rapidly
Source: Percentage Growth Rates 1992-1995 CRS / 1996-2002 CBO
60
50
40
30
20
10
0
55.3
44.4
29.2
23.8
21.6
15.2
10.6
9.1
8.2
7.5
6.9
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
SNF Growth

62 Most Common Post Acute DRGs

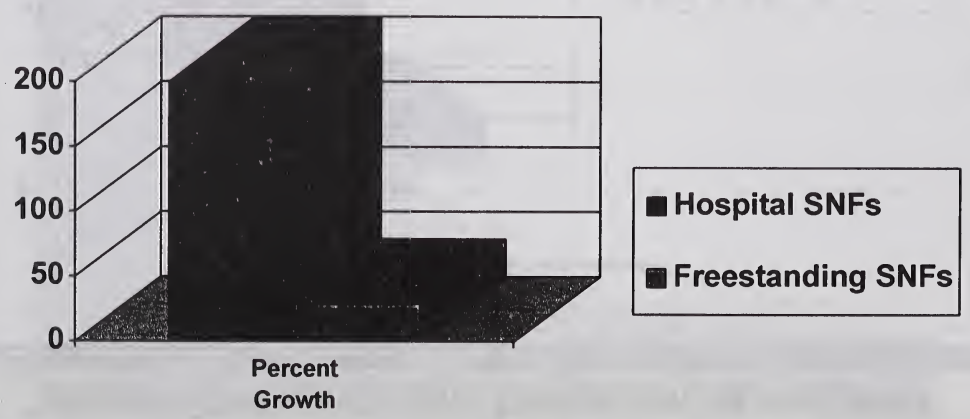
Acute Payments and Length of Stay (LOS)

Source: Federal Register - HCFA Final Rule - 5/31/89 through 9/1/95



Growth in Hospital-based SNFs 1986 through 1994

Source: Prospective Payment Commission



Mrs. JOHNSON. Thank you, Mr. Chies.
Mr. Hafkenschiel.

STATEMENT OF JOSEPH H. HAFKENSCHIEL, PRESIDENT, CALIFORNIA ASSOCIATION FOR HEALTH SERVICES AT HOME, SACRAMENTO, CALIFORNIA; ON BEHALF OF PPS WORK GROUP

Mr. HAFKENSCHIEL. Madam Chair and Members, I am pleased to present testimony on behalf of the California State Association and also the PPS Work Group. I would like to focus my oral remarks on two parts of the administration's budget proposal as it impacts home health care.

First is the proposal to limit part A coverage to 100 visits following a 3-day hospitalization and shifting the balance of the program to part B. Shifting a major proportion of the Medicare home health benefit to part B will do nothing to address the causes of home health expenditure growth. In fact, it will complicate the situation by bifurcating the benefit between two funds with two different systems of administration.

The proposal will not restore the original split in home health payments between parts A and B of Medicare as the administration contends. As shown on the chart on the easel, home health services have been covered and reimbursed under part A every year since the beginning of the program.

On the chart, the red is the coverage under part B and the blue is the coverage under part A.

The part B shift will increase providers' administrative costs by having to track the beneficiaries payment source and having to deal with two different billing systems. It will make it all the more difficult to develop a prospective payment system for home health services by splitting the program into two parts.

Now, let's look at prospective payment. The administration agrees that the key to controlling home health expenditures is to replace the cost reimbursement system with a prospective payment system. The administration's proposal, however, fails to propose a prospective payment methodology. Let me compare and contrast the two proposals.

The administration proposes to retain cost-based reimbursement until an unspecified PPS plan is implemented on October 1, 1999. This preserves all the problematic features of the current system. In order to achieve savings prior to October 1, 1999, the administration's proposal contains a series of adjustments to the current cost-based system which provide a number of negative incentives.

Finally, the administration proposes to implement an unspecified PPS system on October 1, 1999. HCFA has failed to develop a prospective payment system for home health despite being directed to do so by Congress first in 1987 and again in 1990. We should be cautious about their latest timeline.

In contrast to the administration's PPS proposal, the industry over the last 2 years has worked diligently to develop a proposal which has been endorsed by all 50 State associations and 3 national associations. The PPS plan contained in your bill, Mrs. John-

son, H.R. 4229, converts to fixed-per-visit payments within 6 months of enactment. This will end cost-based reimbursement and eliminate the incentive to incur additional costs.

Furthermore, it will end the controversy about which costs are allowable and the inherent potential for fraud and abuse. By eliminating or greatly simplifying the filing and auditing of cost reports, ending cost-based reimbursement could save providers and the Medicare Program tens of millions of dollars annually. This proposal will reduce government involvement in home health care, not increase it.

In short, H.R. 4229 sets forth a specific plan to move the home health benefit from its current cost-based reimbursement system to a system of prospective payment. It provides strong incentives to reduce the cost per visit, the number of visits per episode, and it begins the transition process immediately.

The President has recently stated that Congress should avoid "false choices and not let a historic opportunity to balance the budget slip past." We believe the part B shift proposal is a false choice. We face an opportunity in which the home care industry has achieved near unanimous support for a solution to its own problems. By moving promptly to prospective payment, we can change the home health delivery model from providing as many visits as possible to a model of achieving the best possible outcomes with a minimum use of resources.

We urge the Congress to seize this opportunity and enact prospective payment for home health this year. I would be pleased to answer any questions you may have.

[The prepared statement and attachments follow:]

Statement of Joseph H. Hafkenschiel, President, California Association for Health Services at Home; on Behalf of the PPS Work Group

Mr. Chairman and Members:

My name is Joe Hafkenschiel. I am President of the California Association for Health Services at Home (CAHSAH). Our association represents more than 700 organizations providing home care services in California. I am pleased to present testimony today on behalf of our state association and also on behalf of the PPS Work Group, which is a coalition of more than 25 state and national home health associations dedicated to the prompt implementation of a prospective payment system for Medicare home health services.

There are many complex, interacting factors which contribute to the recent growth in the Medicare home health benefit. Some of these factors are positive for the Medicare program such as the avoidance of hospital and nursing facility stays. Other factors are beyond our control such as the aging of the population. Finally, there are factors we can control such as coverage policy and payment policy.

One factor that is just emerging is that beneficiaries may not be receiving adequate access to home health care through Medicare HMOs. A recent report prepared by Mathematica Policy Research for the Physician Payment Review Commission reported that 36% of patients who were not satisfied with the amount of home health services they received left their Medicare HMOs to return to fee-for-service benefits. These beneficiaries were three times more likely to be beneficiaries with disabilities, over 85 years old, in fair or poor health, with a history of stroke, or whose health had declined in the past year. What could be happening is that beneficiaries enroll in Medicare HMOs, get sick and don't get needed services, dis-enroll and then obtain needed services in the fee-for-service sector, thus driving utilization higher.

So, the reasons behind the growth in home health expenditures are complex. Nevertheless, it is clear that one of the problems is the current cost-based reimbursement system for Medicare home health services. There are at least three serious problems with the current system:

1. It provides few incentives for efficiency.
2. It creates a potential for fraud and abuse.
3. It is not compatible with the incentives provided by managed care.

The home health industry has worked diligently over the last two years to develop a system to replace cost-based reimbursement and eliminate these problems. That system is called a Prospective Payment System or PPS. It can be implemented quickly, it will end cost-based reimbursement, and most importantly, it can generate substantial Medicare home health system savings over the next five years.

As shown by the attached Resolution, the PPS plan developed by the industry has been formally endorsed by the home health associations for all 50 states and the District of Columbia, as well as by the three national home health associations. An earlier version of that plan passed both Houses of Congress and a Conference Committee as part of the Balanced Budget Act of 1995 (H.R. 2491). A revised and improved version of the earlier proposal was reintroduced in the last congressional session (as H.R. 4229) by Congresswoman Nancy Johnson.

By contrast, the Administration's budget proposal contains three measures which take a band-aid approach to the current system:

1. It limits Part A home health coverage to 100 visits following a three-day hospitalization, and shifts the bulk of coverage to Part B.
2. It retains the cost-based reimbursement system until it is replaced by an unspecified Prospective Payment System.
3. It prescribes a series of so-called fraud and abuse initiatives.

I would like to address each of these proposals in turn.

Shifting a major proportion of the Medicare home health benefit to Part B will do nothing to address the causes of home health expenditure growth. In fact, it will complicate the situation by bifurcating the benefit between two funds with two different systems of administration.

The proposal will not restore the original split in home health payments between Parts A and B of Medicare, as the Administration contends. As shown in the attached chart, home health services have been covered and reimbursed principally under Part A every year since the beginning of the program.

It will increase providers' administrative costs by having to track the beneficiaries' payment source and having to deal with two different billing systems. It will make it all the more difficult to develop a prospective payment system for home health services. The estimated $82 billion in expenditures which will be shifted to Part B will create inexorable pressure to raise the part B premium. If the premium is not raised, the funding burden will fall on general tax revenues. In short, the Part B shift is not sound from either a programmatic or a fiscal perspective.

The Administration agrees that the key to controlling home health expenditures is to replace the cost reimbursement system with a prospective payment system. The Administration's proposal, however, fails to propose a prospective payment methodology.

Rather, the Administration proposes to retain cost-based reimbursement until an unspecified PPS plan is implemented on October 1, 1999. This preserves all of the problematic features of the current system including:

- the incentive to providers to incur costs up to the cost limits;
- the incentive to increase the number of visits per patient;
- the cost to providers and the fiscal intermediaries of cost reports and audits; and
- the incompatibility of cost-based reimbursement with managed care.

In order to achieve savings prior to October 1, 1999, the Administration's proposal contains a series of adjustments to the current cost-based system. These include:

- reducing the cost limits to their level on July 1, 1993;
- further reducing the cost limits from 112% of the mean to 105% of the median;
- establishing a new per beneficiary annual limitation; and
- modifying the per beneficiary limitation for regional or national variations in utilization.

These adjustments do not provide appropriate incentives to providers, do not give providers an opportunity to adjust their operations to the new limits, and will jeopardize the viability of agencies with high costs per visit since the adjustments will reduce the current cost limits by more than 15 percent. Agencies which typically have a high cost per visit include hospital-based agencies, small agencies and rural agencies.

Finally, the Administration proposes to implement an unspecified prospective payment system on October 1, 1999. However, HCFA has failed to develop a prospective payment plan for home health despite being directed to do so by Congress in 1987 and again in 1990. Accordingly, it is unlikely that HCFA will be able to design, develop, and implement a prospective payment plan by October 1999. But even if that were to occur, such a plan would not be the product of years of industry thought and input. Nor would the plan be tested. By contrast, the industry's plan has been developed by home health providers of all auspices, and the core concepts of the

plan have been the subject of two years of testing in the Phase II Prospective Payment Demonstration Project authorized by Congress and approved by HCFA.

When the earlier version of the industry's plan passed Congress in 1995, it was scored by the Congressional Budget Office (CBO) as achieving at least $14 billion in savings over 7 years, despite the fact that CBO applied an unprecedented 67% "behavioral adjustment."

The version of the plan that was introduced as H.R. 4229 has been scored by former CBO officials at Price Waterhouse as achieving savings in the $10 billion range over 5 years.

It is important to understand, however, that whatever amount of savings is determined appropriate for home health can be achieved under the plan's basic structure.

In contrast to the Administration's PPS proposal, the PPS Plan contained in H.R. 4229 converts to fixed per visit payments within six months of enactment. This will end cost-based reimbursement and eliminate the incentive to incur additional costs. Furthermore, it will end the controversy about which costs are allowable and the inherent potential for fraud and abuse. By eliminating or greatly simplifying the process of funding and auditing cost reports, ending cost-based reimbursement could save providers and the Medicare program tens of millions of dollars annually.

H.R. 4229 contains per patient and per episode limits which provide progressively stronger incentives to providers to control the number of visits provided per patient. The per episode limit uses the case-mix classification system developed by the Health Care Financing Administration's current demonstration project. The plan also contains a limit on care for patients whose care continues beyond 120 days. The plan contains a savings sharing provision which will provide incentives to further reduce the number of visits per patient.

In short, the H.R. 4229 sets forth a specific process to move the home health benefit from its current cost-based reimbursement system to a system of prospective payment. It provides strong incentives to reduce the cost per visit and the number of visits per episode. And, it begins the transition process immediately.

The final area of the Administration's budget proposal I would like to address is the so-called fraud and abuse initiatives. Home care providers in California have been exposed to HCFA's current fraud and abuse initiative, Operation Restore Trust (ORT), for the past year. As far as we know, ORT has not identified any fraud and abuse but has resulted in highly questionable closures of approximately twenty agencies. I would caution the Congress about expanding ORT without a showing of the results to date.

The principal proposal in the Administration's budget under the fraud and abuse initiative is to redefine "homebound." Homebound is currently defined in the Home Health Agency Manual by a page and a half of text. Essentially, a patient is considered homebound if there exists a normal inability to leave home and leaving home would require a considerable and taxing effort. The current definition was developed as part of HCFA's settlement of a lawsuit in 1989 requiring them to specify criteria for coverage of home health services. Congress may very well want to redefine homebound, but should be clear it is changing the coverage rules, and beneficiaries may be forced to obtain needed services from other sectors of the health care system.

The President has recently stated that Congress should avoid "false choices" and not let an historic opportunity to balance the budget slip past. We believe the Part B shift proposal is a "false choice." We face an historic opportunity in which the home care industry has achieved near unanimous support for a solution to its own problems. By moving promptly to prospective payment, we can change the home health delivery model from providing as many visits as possible to achieving the best possible outcomes with minimum use of resources. We urge you to seize this historic opportunity and enact prospective payment for home health this year.

I would be pleased to answer any questions.

Declaration of Support for Implementation of a Prospective Payment System for Medicare Home Health Services

SEPTEMBER 25, 1996

Whereas the health care industry is facing rapid and significant changes both in the delivery of services and its relationships with payors;

Whereas the health care delivery system is increasingly relying on some form of managed care to encourage providers to achieve patient centered, favorable outcomes in the most cost effective manner possible;

Whereas the current structure of cost reimbursement for Medicare home health services is counterproductive to the goals of delivering high quality, cost effective, and medically necessary services;

Whereas the home health industry must move to a prospective payment system to operate more consistently with non-Medicare reimbursement systems;

Whereas the Congress and the Administration have indicated that the rate of expenditure growth in the Medicare home health benefit, combined with the overall financial state of the Medicare program, requires the adoption of some measure to reduce the growth rate in Medicare home health expenditures per patient in future years;

Whereas the home health industry considers copayments, at any level, an unacceptable and improper burden on the infirm, elderly, and disabled who receive Medicare home health services given the significant contributions made by these individuals and their families as primary caregivers in the home setting;

Whereas the home health industry considers proposals to "bundle" home health payment with other Medicare payment, such as hospital services, to be inappropriate and counterproductive in achieving the goal of providing care in the most cost effective setting possible;

Whereas the Congress has requested the home health industry to offer a substitute for copayments and bundling that provides incentives for reducing the rate of expenditure growth while preserving access to medically necessary home health services;

Whereas the home health industry considers the implementation of a prospective payment system to be the appropriate mechanism to address the needs and concerns of patients, the Medicare program, and the home health industry;

Be It Resolved that the following organizations, comprised of the National and State Associations representing the interests of Medicare certified home health agencies, and the patients they serve, nationwide commit their support for the enactment and implementation of a prospective payment system which is entitled "The Revised Unified Plan", as attached hereto.

Signed,

William Ehey (Billy)
Alabama Association of Home Health Agencies

Monica Braeuer
Illinois Home Care Council

Michelle Reed
Montana Association of Home Health Agencies

Judith McKay
Oregon Association for Home Care

Richie Sumner
Alaska Home Care Association

Michael Sullivan
Indiana Association for Home Care, Inc.

Patricia Mahonken
Nebraska Association of Home and Community Health Agencies

Terry O'M. Stark
Pennsylvania Association of Home Health Agencies

Nathalie Russell
Arizona Association for Home Care

Larry Breeding
Iowa Association for Home Care

Ruth Applebaum
Home Health Care Association of Nevada

Isabel Torres
Puerto Rico Home Health Agencies and Hospice Association

Charles D. Martin
Home Care Association of Arkansas

Linda Lubensky
Kansas Home Care Association

Mary Bowers
Rhode Island Partnership for Home Care, Inc.

Theresa L. Corriveau
Home Care and Hospice Association of California

Karen P. Hinkle
Kentucky Home Health Association

Sheila Vagos
South Carolina Home Care Association

Ellen Carson
Home Care Association of Colorado

Dabney Allen
Homecare Association of Louisiana

Michelle Miller
South Dakota Home Health Association

Virginia S. Humphrey
Connecticut Association for Home Care, Inc.

Juliana L'Heureux
Home Care Alliance of Maine

Connie E. Ray
Tennessee Association for Home Care, Inc.

Meg Maley
Delaware Association for Home and Community Care

Diane Pedersen
Maryland Association for Home Care, Inc.

Cassie King
Tennessee Association for Home Care

Eileen Barefield
Capital Home Health Association

Pat M. Kelleher
Home & Health Care Association of Massachusetts

Gina Cacciapuoti
Utah Association of Home Health Agencies

Marjory Hay
Associated Home Health Industries of Florida, Inc.

Peggy Means
Shenandoah Council for Home Care Aide Services

Peter Cobb
Vermont Assembly of Home Health Agencies

Judy Adams
Georgia Association of Home Health Agencies

Rosalind L. Stack
Michigan Home Health Association

Martha B. Pulley
Virginia Association for Home Care

Fredd S. Hogle
Georgia Association of Community Care Providers

Debra Kilduff
Minnesota Home Care Association

Jeannette Weyrich
Home Care Association of Washington

Donna L. Westphalen
Hawaii Association for Home Care

Mary Lee Nations
Mississippi Association for Home Care

Jan Blair Hunter
West Virginia Council of Home Health Agencies

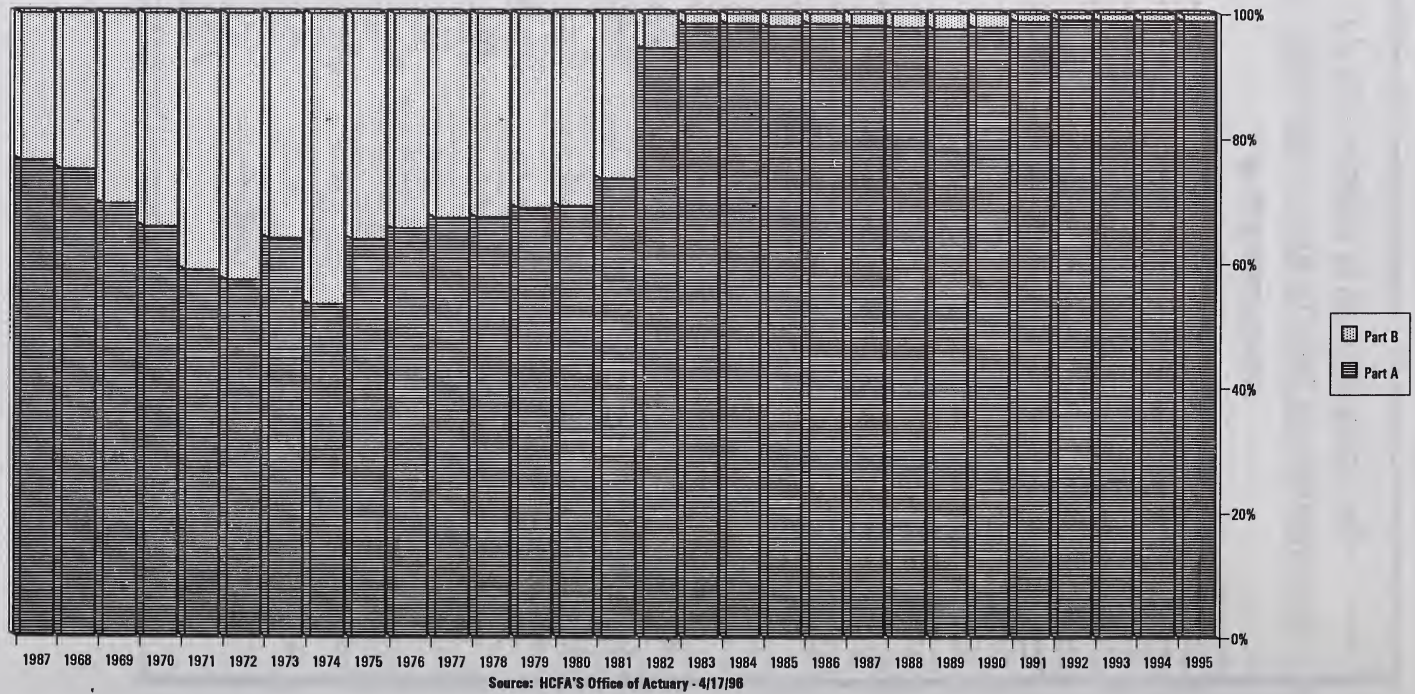
Leslie Morgan
Maine Association of Home Health Agencies

Mary Schantz
Missouri Alliance for Home Care

Wanda Denton
Home Health Care Alliance of Wyoming

Home Health Services and Staffing Association • National Association for Home Care • Visiting Nurse Association of America

"The President's proposal restores the original split of home health care payments between Parts A and B of Medicare."
Highlights of the President's Medicare Reform Package.



Source: HCFA'S Office of Actuary - 4/17/96

Mrs. JOHNSON. Thank you very much.
Ms. Cushman.

STATEMENT OF MARGARET J. CUSHMAN, PRESIDENT, VNA HEALTH CARE, INC., PLAINVILLE, CONNECTICUT; ON BEHALF OF NATIONAL ASSOCIATION FOR HOME CARE

Ms. CUSHMAN. Thank you, Madam Chairman. My name is Margaret Cushman and I am president of VNA Health Care, Inc., in Hartford-Plainville, Connecticut. I also chaired the NAHC, National Association for Home Care, government affairs committee, and I am on its prospective payment task force.

We thank you, the Members of the Subcommittee, and especially you, Mrs. Johnson, for the support you have expressed for prospective payment for home care and for your leadership in helping to defeat proposals to bundle home care payments into other provider payments and to shift home care from part A to part B of Medicare. We also appreciate the leadership of Representatives Cardin and Portman for introducing the Medicare Hospice Benefit Amendments of 1997. This bill, cosponsored by many Committee Members, would greatly help Medicare beneficiaries in need of end-of-life care.

First let me speak to prospective payment. Congress currently has before it a unique opportunity to improve the Medicare home care benefit in a way that the home care industry supports and will stand behind. The unified prospective payment plan introduced last year by Representative Johnson provides the best elements of prospective payment from provisions formerly in the Balanced Budget Act and in H.R. 2530.

Our goal in crafting this prospective payment plan was to accommodate deficit reduction requirements, to substitute for home care copays and bundling, and to address HCFA's concerns about implementation. Let me be direct regarding the context in which we offer this proposal.

In 1995, when the industry found copayment and bundling proposals unacceptable, Congress challenged us to develop alternative proposals. This prospective payment proposal was developed as that alternative and it is in that context that we offer it today. Prospective payment is a vast improvement over current cost-based reimbursement. Cost-based reimbursement is complex, costly to administer, and offers no incentives for provider efficiency.

Prospective payment gives providers incentive to reduce both visits and costs in the total case per patient. Our plan entails a three-phase approach for achieving episodic prospective pay, starting immediately with an interim system using existing data and processes, moving to an interim episodic system with a refined case mix adjuster, and ultimately requires development within 5 years of a full per-episode prospective payment system.

Under Federal law and State practice acts, we have the means to prevent inappropriate substitution of home health aides for other skilled professional staff. Eligibility requirements would still require skilled care. All nurse practice acts would take care of the level of professionals needed to provide services.

We are deeply concerned that the CBO may again impose the 66⅔-percent offset to the plan, dramatically reducing our plan savings. An offset of this magnitude is entirely unjustified and would make it virtually impossible to offer reasonable proposals for the provision of care without harm to beneficiaries.

Here are some highlights that I would like to share on the President's budget: By design, the prospective payment system for hospitals has led to shorter hospital stays and increased the need for postacute care. It is inappropriate to lay the entire penalty for that increase in cost of after hospital care at the door of those services.

Beyond our concern that home care would be cut disproportionately in the President's budget, we are deeply concerned that the proposal would reduce home care services for needy Medicare beneficiaries. We are concerned about the shift from A to B, restrictions in eligibility for home care, the notion of denying home care based on normative standards, and lumping postacute services into a single care payment.

The A to B transfer has been eloquently addressed both in your questions and by Mr. Hafkenschiel. So, I will move on to other issues.

One of the problems we are concerned about is the notion of the prospective payment system suggested by the administration. While they do not give a detailed plan for the future, there are some suggestions of what might be introduced more immediately.

The proposal as listed is flawed in that it essentially continues the present cost-based reimbursement system with no incentives to reduce costs. It proposes that the Secretary devise a new plan without congressional oversight or participation by the industry or consumer groups. It would reduce home health cost limits and per-beneficiary limits by 15 percent prior to implementation of prospective payment, which is a drastic and unnecessary reduction.

In addition to these proposals, the administration would delay updates in Medicare cost limits for 3 months, which would reduce limits approximately $10 per visit and nearly $5 per home health aide visit. They would maintain savings from the current home health aide freeze, which would reduce the Medicare cost limits by approximately $7 per visit or an additional 7 percent. To combine these two provisions would reduce the cost limits to home care providers by approximately 17 percent, which is unnecessary if we have a prospective payment system being reduced.

They would also provide for restrictions in eligibility for homebound which would restrict current beneficiary eligibility. They would change definitions for part time and intermittent, further denying eligibility. It would deny care outside normative standards for home care, a notion which is troublesome given the admitted lack of a current case mix adjuster to predict prospective payment for home care.

We are also opposed to bundling home care payments with other postacute providers and are very interested in having waiver of liability reinstituted which both you, Mrs. Johnson, and Mrs. Kennelly, last year helped to support us.

I would be happy to answer any questions now, and I have much more detail in my written testimony.

[The prepared statement and attachments follow:]

Statement of Margaret J. Cushman, President, VNA Health Care, Inc., Plainville, Connecticut; on Behalf of National Association for Home Care

Mr. Chairman,

Thank you for the opportunity to present testimony today on issues related to the Medicare home care benefit. My name is Margaret J. Cushman. I am the President of VNA Health Care in Hartford-Plainville, Connecticut. I also chair the Government Affairs Committee of the National Association for Home Care (NAHC), as well as serve on the NAHC Prospective Payment System (PPS) Task Force.

The National Association for Home Care is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among NAHC's members are every type of home care agency, including nonprofit agencies, like the Visiting Nurse Associations, for-profit chains, hospital-based agencies and freestanding agencies.

The National Association for Home Care thanks you, Mr. Chairman, and Members of the Committee, especially Mrs. Johnson, for the support you have expressed for PPS for home care, as well as your leadership in helping to defeat proposals to bundle home care payments into other provider payments and to shift home care from Part A to Part B of Medicare.

NAHC is deeply appreciative of the support and attention PPS for home care has received from this Committee and in this Congress. We have been advocating such a system for more than a decade. Congress, too, has been pushing the Administration for development of a PPS for home care for many years. We were very pleased that proposals to implement such a system were included in the balanced budget plans offered in the last Congress by both parties, and that a PPS plan was passed by the full Congress as a part of HR2491, the Seven Year Balanced Budget Act (BBA), in lieu of copays. We also deeply appreciate the introduction of the industry's Revised Unified PPS plan, HR4229, by Mrs. Johnson.

We also greatly appreciate the leadership of Representatives Cardin and Portman for introducing the Medicare Hospice Benefit Amendments of 1997 (HR521). This bill, which has been cosponsored by Reps. Kennelly, Stark, English, Matsui, McDermott, McNulty, Dunn, and Bunning of the Committee, would greatly help improve hospice care for Medicare beneficiaries in need of end-of-life caregiving.

The Hospice Benefit Amendments would correct several out-dated provisions in the Medicare law, as well as put in place provisions that would help assure fiscal responsibility in the benefit.

The Medicare hospice benefit makes it possible for America's elderly and disabled individuals to die at peace in their own homes, without the use of costly end-of-life health care services. Hospice works for the millions of patients and families who have experienced it, and for the Medicare program.

I'd like to ask permission, Mr. Chairman, to have my full written statement, along with the following attachments, included in the hearing record:

- a detailed description of the industry's Revised Unified Plan,
- a chart showing the characteristics of Medicare home care patients,
- detailed comments on the President's FY98 budget proposal, and
- a copy of a letter from home health and hospice associations in all 50 states opposing transferring home care coverage from Part A to Part B of Medicare.

My testimony is organized as follows:

- factors affecting growth in home care,
- concerns about and efforts to address fraud and abuse,
- discussion of PPS, and
- discussion of the President's FY98 budget proposals and other proposals that affect home care.

I. Factors Affecting Growth in Home Care

Home care encompasses a broad spectrum of both health and social services that can be delivered to recovering, disabled or chronically ill persons in their homes. These services include the traditional core of professional nursing and home care aide services as well as physical therapy, occupational therapy, speech therapy, and medical social services.

Generally home care is appropriate whenever a person needs health care assistance that cannot be easily or effectively provided solely by a family member or friend for a short or long period of time. There are many situations and conditions for which home care services are especially appropriate. Technology advancements mean that every day more people are able to be cared for effectively and efficiently at home even if they have illnesses that, at one time, were only treatable in hospitals or institutions.

The home health benefit has been an evolving benefit for most, if not all, of its existence in the Medicare program. In Medicare's earliest years, home health expenditures amounted to only about 1% of the total. Today, approximately 9% of total Medicare payments are made for home health services. Therefore, while the benefit has increased each year, it still represents a small proportion of Medicare spending.

In 1996, nearly 4 million Americans received Medicare home health services, representing an estimated $18 billion in Medicare spending. Much of the increase over time can be attributed to one-time expansions or clarifications that were specifically designed to allow more individuals access to additional in-home services.

Home health growth, however, is expected to moderate and fall to more modest levels in the next few years. The HCFA Office of the Actuary expects annual growth in the volume of visits to steadily decrease to around 6% through the year 2000.

Reductions in Hospital Lengths of Stay

Growth in the home health benefit must not be looked at in isolation. There is a direct connection between the effect of PPS on hospitals and the growth in the home care benefit. PPS has made it in the hospitals' best interest to move patients out of hospitals as soon as possible, and to collect the full DRG payment for fewer days of care. In fact, over the last six years, lengths of stays in hospitals fell 31% in the DRGs most associated with post-acute care use. Average costs per discharge also declined about 6% during the same time period.

Despite a decade of continual reductions in the hospital lengths of stay, the Medicare hospital updates have never reflected these changes. Decreases in the hospital lengths of stay should be reflected in Medicare payments to hospitals. In the President's FY98 budget, home health and other post-acute care providers are penalized for the growth in their areas that have been fueled by hospitals. Hospital payment rates should be reduced to reflect this change, rather than hitting home care and other post-acute care providers.

Several other factors explain the growth in the home health benefit not associated with quicker discharges of more acutely ill patients from hospitals.

Coverage Clarification

In the mid-1980s, Medicare adopted documentation and claims processing practices that created general uncertainty among agencies about what services would be covered. The result was a "chilling effect" under which some Medicare covered claims were diverted to Medicaid and some patients went without care. This "denials crisis" led in 1987 to a lawsuit (Duggan v. Bowen) brought by a coalition led by Representative Harley Staggers and Representative Claude Pepper, consumer groups and NAHC.

The successful conclusion of this suit led to a rewrite of the Medicare home health payment policies. Just as lack of clarity and arbitrariness had depressed growth rates in the preceding years, the policy clarifications that resulted from the court case allowed the program for the first time to provide beneficiaries the level and type of services that Congress intended.

The correlation between the policy clarifications and the increase in visits is unmistakable. The first upturn in visits (25%) came in 1989 when the clarifications were announced; and an even larger increase took place (50%) in 1990, the first full year the new policies were in effect.

Cost Effectiveness

Home health has moved well beyond its traditional boundaries, making it possible for patients to prevent, reduce or eliminate altogether their need for more costly inpatient treatment. It is also important to note that while growth in home care has been experienced in the number of visits provided per patient, home care's costs have remained steady over the last decade, making home care still one of the best health care buys.

An Aging Population

The aging of the U.S. population will continue to influence future need for home health services. Older individuals are more likely to need home care and they are likely to use more home care services than younger home health patients. For example, the National Medical Expenditures Survey found that individuals over age 85 are three times more likely to use home care as the general elderly population, and their resource consumption was also significantly higher. Individuals over age 65 used an average of 65 visits whereas individuals over age 85 used an average of 75 visits.

Improved Access

Throughout much of the 1980s, the home care industry, along with the rest of health care, was experiencing a personnel shortage. Although there are still acute shortages of certain disciplines, conditions have substantially improved. This increase in available staff allowed the number of certified home health agencies to increase from 5,676 in 1989 to 9,923 in 1996. Although access varies somewhat from state to state, for the most part enrollees who need home health care now have access to it.

Public Awareness and Preference

The past decade has seen dramatic increases in awareness among physicians and patients about the home as an appropriate, safe and often cost-effective setting for the delivery for health care services. For example, a 1985 survey found that only 38% of Americans knew about home care; by 1988, over 90% of the public understood home care to be an appropriate method of delivering health care, and supported its expansion to cover long-term care services as well. A 1992 poll found that the American public supports home care by a margin of nine to one over institutional care. Nearly 82% of all accredited medical schools now offer home health care training in their curricula.

Technological Advances

Over the years, sophisticated technological advances have made possible a level of care in the home that previously was only available in hospitals and other institutions. The most significant of these advances has been the introduction of home infusion therapy and radical improvements in ventilator equipment.

Reductions in home care spending are likely to result in greater Medicare expenditures for hospital inpatient and emergency care, physician services, and nursing home care. Home health care serves as the safety net for patients who are discharged from acute and rehabilitation hospitals after shorter lengths of stay.

II. Concerns About and Efforts to Address Fraud and Abuse

As in any area, growth brings with it the potential for unethical or illegal behavior. NAHC strongly believes it is the responsibility of all parties involved—patients, payors, and providers—to act aggressively to uncover, report, and act against fraudulent or abusive home care providers.

The National Association for Home Care (NAHC) has taken a leadership role in combatting fraud and abuse. It has been engaged in a longstanding effort to maintain the highest degree of ethics and values in the health care industry through a combination of member education, cooperation with and assistance to enforcement agencies, and consistent support of federal legislative proposals designed to combat abuses in health care programs.

In January 1994, NAHC implemented a broad new policy governing member conduct. While America has enhanced home care as the site of choice for meeting its health care needs, the growth of the industry has unfortunately been accompanied by a few unscrupulous providers of care who seek only to profit illegally at public expense. The incidence of established fraud in home care services is low. However, even a single occurrence of fraud or abuse is not acceptable and must be eliminated.

The principles of NAHC's policy are as follows:

1. Policy on Member Self-Regulation

Where a NAHC member, agency, individual member, or an applicant for membership has been determined or is controlled by an individual who has been determined to have violated a criminal or civil law in either Federal or State Court on issues related to fraud and abuse, the NAHC Board of Directors may consider the imposition of sanctions, including the termination or rejection of NAHC membership.

2. Policy on Public Relations

NAHC shall respond proactively and reactively to any public relations crisis concerning fraud and abuse activity in home care and hospice.

3. Policy on Education of Members

Consistent with its mission and commitment to provide educational opportunities for members, and for the purposes of promoting standards of quality and ethics in the delivery of home care and hospice services, NAHC will provide education regarding issues of fraud and abuse in home care and hospice.

4. Policy on Enforcement

It is the responsibility of any NAHC staff person or any NAHC member to report to the appropriate legal authority any violation of fraud and abuse laws. No report shall be made by NAHC staff except where sufficient information has been obtained which demonstrates that there is a substantial likelihood that the law has been violated. Witnessing or having knowledge of an crime and not reporting it would constitute unethical behavior.

When government enforcement officials fail to act to address flagrant violation of the fraud and abuse law, NAHC may bring a civil enforcement action against the unscrupulous provider where authorized by a super majority of the Board of Directors.

5. Policy on Supporting Fraud and Abuse Legislation

NAHC shall actively support and/or initiate legislative and regulatory measures appropriate to prevent or combat fraud and abuse in the home care and hospice industries.

6. Policy on Request for Assistance

NAHC's assistance to member agencies under investigation for health care fraud and abuse shall be available when it is determined that it is the best interests of the home care and hospice industry at large.

This policy is the embodiment of the NAHC efforts since its inception in 1983. Its enactment in 1994 was an affirmation of NAHC's commitment to maintain a leadership role in this troubling area. Evidence of NAHC's commitment is most evident in support of legislative efforts to control fraud. In 1993 and 1994, and continuing today, NAHC has publicly supported and worked to advance legislation which would expand existing health care fraud laws under Medicare and Medicaid to all payors in health care. This expansion would work to eliminate activities which escape scrutiny because of the lack of controls in certain states which allow for conduct with private health insurance payments that would be illegal if federal payments were involved. NAHC has also aggressively supported the creation of a private right of action under federal anti-kickback laws to supplement the limited resources of government enforcement agencies. In this same respect, NAHC has repeatedly supported increased funding for the Office of Inspector General at HHS.

Legislation is also needed to control the quality and delivery of home infusion therapy services. This $3 billion segment of the home care industry operates under virtually no regulatory controls and presents an environment for improper, but not necessarily illegal, conduct to occur. In 1994, NAHC highlighted the need for controlling legislation such as that offered by Congressman Sherrod Brown in the so-called "Sara Weber" bill.

Fraud has also existed within the Medicaid programs. The states' Medicaid anti-fraud units have proven success in attacking this area. NAHC has and continues to support the continuation of these programs.

Legislation alone cannot control fraud and abuse. Health care providers must have a comprehensive understanding of acceptable standards of conduct. Internal self-audit and self-enforcement must be done to minimize the risk of illegal activities. Over the past several years NAHC has provided extensive education on the issues involved in health care fraud. National workshops have been held at our regional conferences, annual meetings, and annual law symposiums. State home care associations have joined in this effort to extend this education to the greatest degree possible.

NAHC believes that increased public awareness is a valuable means of oversight and that the public must be fully involved in the process of fighting fraud. It is the health care consumer and the taxpayer who are ultimately the injured parties. While the government should increase the information it provides to the public about known schemes and scams, the health care industry must also do its part. In accordance with the NAHC fraud and abuse policy, the home care industry has not only cooperated with media investigations but has worked to engage the attention of the media to focus on important areas of concern.

One of the most important roles that the home care industry plays in eliminating fraud and abuse is to lend its knowledge and expertise to enforcement authorities. Over the years, NAHC has acted as an extension of the investigatory arm of federal and state enforcement authorities. On the simplest of levels, NAHC has put individuals and providers of services who have evidence of fraudulent conduct in touch with the HHS Office of Inspector General. On a deeper level, NAHC has provided guidance to enforcement authorities on areas in which resources might be targeted in their home care efforts.

Historically, fraud and abuse in health care has taken the form of false claims in Medicare cost reports, billings for services never rendered, and kickbacks for referrals. These types of fraud are now being replaced with an entirely different form of abuse found in managed care. While in the traditional fee-for-service system incentives exist for overutilization and overcharging. But managed care may create financial incentives to improperly underutilize care. The health care consumer is harmed doubly in these circumstances; financially, care is prepurchased but not delivered; and healthwise, necessary care is lost. NAHC strongly recommends that Congress and the enforcement authorities take a long hard look into the abuses in managed care. New strategies must be developed to address this new type of fraud. Clinicians, rather than accountants, will need to operate at the heart of this effort. Good managed care can help bring about economy and efficiency in health care. Bad managed care, controlled by financial greed, can mean the death of the patient.

Recommendations to Combat Fraud and Abuse

During the 104th Congress, NAHC played an active role in helping shape an anti-fraud health care package. Ultimately, these proposals were incorporated into the Health Insurance Portability and Accountability Act, P.L. 104–191, that was passed into law.

Passage of the anti-fraud package marks a good first step in eliminating waste, fraud and abuse in our health care system. There are, however, some specific issues within home care that need to be addressed by anti-fraud legislation.

Congress should continue its work in combating waste, fraud and abuse in our nation's health care system by passing a home care specific anti-fraud package that includes:

- Limiting Agencies' Ability to Subcontract Care. Medicare certified home health agencies should be allowed to utilize only a limited amount of subcontracted care for the dominate health care service, such as nursing, which they provide.
- Mandating Freedom of Choice Information. Hospitals, physicians, and other health care providers, should be required to give patients full information about the availability of Medicare certified home health agencies serving the areas in which the patients reside, and should be prohibited from steering patients to certain agencies.
- Prohibiting Home Health Agencies from Assisting Physicians in Care Billing. Home health agencies should be prohibited from providing record keeping and bill preparation services to physicians for their role in home care.
- Requiring Home Health Care Administrators to Meet Certification and Accreditation Standards. The last several years have seen a unbridled growth in the number of Medicare certified home health agencies. Home care agency administrators should be required to meet high and rigorous standards for all aspects of running an agency, including issues that affect quality of care.

III. PPS for Home Care

Congress has before it a unique opportunity to work closely with the home care community to improve the Medicare home care benefit. The Revised Unified PPS plan offered to Congress by the home care industry and introduced by Representative Nancy Johnson (HR4229) incorporates the best elements of the home care PPS provisions in the Balanced Budget Act (BBA) passed by Congress and HR2530, the Blue Dog Coalition's budget plan introduced in the 104th Congress.

The Revised Unified PPS Plan represents the most advanced thinking that's been done in developing a PPS plan. It also represents a substantial improvement over the current Medicare cost-based reimbursement system.

Let me be very direct regarding the context in which we are offering this PPS proposal. In 1995, Congress proposed sizable savings from the Medicare program, a portion of which was to come from home care. Since the industry found copayments and bundling unacceptable, Congress challenged us to develop a more acceptable way of achieving the required savings. This PPS proposal was developed as an alternative to home care copays, bundling, and other onerous ideas, and that is the context in which we are offering it today.

Our goal was to develop a PPS plan that 1) the home care industry could support, 2) would use the best that both the Republican (BBA) and Democratic (HR2530) plans had to offer, 3) would address concerns raised about the PPS plans in both the BBA and HR2530, 4) would accommodate deficit reduction requirements, 5) would substitute for home care copays and bundling, and 6) would address HCFA's concerns about feasibility of implementation on a timely basis.

Advantages of PPS

PPS offers numerous advantages to the Medicare program over the current cost-based reimbursement methodology. Under current law, home health agencies are reimbursed for the allowable costs which they incur in caring for Medicare patients up to a per visit cap. Cost reimbursement, however, has been criticized because it is complex and costly to administer, because the amounts that are paid are subject to disallowance and recoupment long after the services have been rendered and because it offers no incentives for provider efficiency.

PPS, by providing desirable, market-like incentives that encourage the efficient and effective provision of care, would avoid these problems because payment rates would be established in advance.

PPS, by providing financial incentives for home care agencies to reduce both visit and total case costs, will achieve Medicare savings without restricting beneficiary access to high quality home care services. PPS properly places the burden to be efficient in the provision of care on providers and not beneficiaries. Alternatives to PPS, like copayments and bundling, create barriers to high quality home care services by increasing a beneficiary's out-of-pocket expenses and restricting access to post-acute care services.

Revised Unified PPS Plan

The Revised Unified PPS Plan that we are testifying in support of today is a modification of the original unified plan submitted to Congress in 1995.

The goal of the home care provider community is to manage the growth of Medicare home health expenditures in a manner that promotes efficiency and preserves access to quality care for Medicare beneficiaries. This will be accomplished through the development and implementation of an episodic prospective payment system as soon as feasible. Our goal was to develop an episodic system which would:

- be developed cooperatively by HHS, the industry, and Congress,
- be acceptable to the industry,
- include extended care,
- be submitted to Congress one year in advance of implementation, and within four years of enactment of legislation,
- be implemented only after Congressional approval,
- include adjustments for new requirements (such as OSHA) or changes in technology or care practices,
- be based on a case-mix adjuster that reflects the differences in cost for different types of patients,
- prevent the imposition of home care copays, bundling, or other benefit limits,
- implement a per-episode PPS as soon as possible, and
- do as little harm as possible to home care patients and providers in implementing an untested system.

This plan, which represents years of work and refinement by the home care industry, calls for a three-phase approach to achieving episodic PPS. It starts with an interim PPS plan that utilizes existing data and processes and moves to an episodic PPS with a refined case-mix adjuster and would require the development, within five years, of a per-episode PPS with a case-mix adjuster that adequately distinguishes the cost of providing services to various types of patients.

Phase 1 of the Plan would implement a prospectively-set standard per-visit payment with an annual aggregate per-patient limit that applies to all visits. Phase 2 would put in place prospectively set standard per-visit payments with an annual aggregate episode limit for days 1–120 and an annual aggregate per patient limit for visits after 120 days. Phase 3 puts in place a per-episode PPS.

This PPS plan would give home care providers incentives to reduce costs and increase efficiency through a provision in which they would be allowed to keep a portion of the difference between the total per visit payments and the agency's annual aggregate cap. This provision differs from the way PPS for hospitals was implemented, in which hospitals are allowed to retain the entire difference between the DRG payment rate and the cost of care. Under the revised unified PPS proposal, home care providers would be allowed to retain 50 percent of the difference, up to a cap, with the balance of the savings used for the exceptions process.

Scoring

NAHC has been working with the accounting firm of Price Waterhouse in reviewing the potential cost savings available through this proposal. We believe it to represent savings roughly equivalent to the savings offered under the Administration's PPS proposal and have built into the proposal a number of components that can be adjusted to achieve necessary savings.

We are deeply concerned about certain assumptions the Congressional Budget Office has employed in scoring PPS proposals for home care. In assessing the prospective payment proposal included in HR2491, CBO imposed a 66 2/3% offset that had the effect of dramatically reducing potential savings the proposal could have achieved. This offset reflects CBO's assumptions of behavioral changes on the part of home health care providers in response to this proposal, as well as their assumption of the proposal's effectiveness.

CBO used this two-thirds offset to calculate net savings for the home health prospective payment provision, meaning that the sum of gross savings for each provision of the proposal was reduced by two-thirds. Under this offset, a proposal scored at $14.2 billion in savings over seven years, as was the PPS proposal in the BBA, actually would reduce Medicare home health expenditures by $42.6 billion over seven years, or three times the scored amount.

Never before, to our knowledge, has CBO employed such a dramatically high assumption of gaming. An offset of this magnitude is entirely unjustified and makes it much more difficult for home care to present a proposal offering necessary savings that does not inflict great hidden harm to home care beneficiaries.

We greatly appreciate the interest Mrs. Johnson and others on the Committee have demonstrated in this issue and we appeal to the Committee for help in encouraging CBO to employ realistic assumptions that do not penalize home care providers and patients.

History of PPS

NAHC has long supported the development of a prospective payment system for home care. NAHC championed the initial PPS demonstration legislation that Congress passed in 1983 as part of the Orphan Drug Act (P.L. 97–414). In that legislation, Congress required the Medicare program to test alternative reimbursement methodologies to determine the most cost effective and efficient way of providing care, including fee schedules, prospective payment, and capitation payments.

Following the passage of this legislation, the industry, through the National Association for Home Care, created its first Prospective Payment Task Force. When the demonstrations authorized under that legislation were delayed in 1985 by the Office of Management and Budget, NAHC stepped in and partially funded the Georgetown University study on patient classification.

The U.S. Department of Health and Human Services (DHHS) did not undertake any serious effort to follow through with the study required in the 1983 legislation. Accordingly, the industry sought a stronger mandate from Congress.

With the Omnibus Budget Reconciliation Act of 1987 (P.L. 100–203), Congress required that DHHS design a prospective payment demonstration in a manner that would enable the Secretary to evaluate the effects of various methods of prospective payments (including payments on a per visit, per case, and per episode basis) on program expenditures, as well as beneficiaries' access to care. An interim report was required by Congress within one year after enactment of the legislation. A final report was due 4 years after enactment. The demonstration was set to begin no later than July 1, 1988.

The Health Care Financing Administration (HCFA) was unable to move the demonstration project forward on a timely basis and sought a delay from Congress. As part of the Medicare Catastrophic Protection Act of 1988, OBRA–87 was amended to modify the effective date from July 1, 1988 to April 1, 1989.

After nearly three years with limited effort by DHHS, Congress, at the request of the home health industry, once again intervened in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101–508). Congress directed HCFA to research and report back to Congress on whether to move cost-based providers, including home health agencies, to some form of alternative reimbursement. DHHS was required to submit a report to Congress that included a proposal for prospective payment for home health agencies by September 1, 1993. The Prospective Payment Assessment Commission was to analyze the DHHS proposal and report to Congress by March 1, 1994.

In developing this proposal, DHHS was required to:

(1) provide for appropriate limits on home care expenditures;

(2) account for changes in patient case-mix, severity of illness, volume of cases, and the development of new technologies and standards of medical practice;

(3) consider the need to increase payment for outlier cases, those cases which exceed the average length or cost of treatment;

(4) address the varying wage-related costs among agencies; and

(5) analyze the feasibility and appropriateness of establishing the episode of illness as the basic unit for making payments.

Ultimately, HCFA initiated a two phase demonstration project to study prospective payment for home health services. In Phase 1, HCFA experimented with a per visit prospective payment methodology. That project, which concluded in 1994, found limited effect on the behavioral actions of home health agencies and expenditure through the use of a per visit method of reimbursement.

Phase 2 of the demonstration project was initiated in March, 1995. Phase 2 is intended to study the behavioral reaction to a per episode based prospective payment system using a case-mix adjustor that classifies patients into one of eighteen categories. As the result of the weaknesses of the case-mix adjustor, explaining only 9.7% of variation in costs for various types of patients, HCFA limited the focus of the demonstration project to analyzing behavioral changes for participant home health agencies. It is expected that a final report will be issued on Phase 2 of the demonstration project in either 1999 or 2000.

We would like to reiterate that the industry's Revised Unified PPS Proposal, while an improvement over the current cost-based reimbursement system, is being offered solely in the context of deficit reduction as an alternative to other home care savings proposals.

Some alternatives, including shifting some home care from Medicare Part A to Part B, placing copayments on Medicare home health visits, and bundling home care payments into hospital DRGs or other provider payments, would have serious detrimental effects on the nearly 4 million Americans who rely on quality home health care. Moreover, these proposals could severely limit access to home care, limiting health care choices for our Nation's elderly and disabled to more costly institutions.

We were extremely gratified that in the BBA, the Committee abandoned home health copayments and bundling in favor of a prospective payment system (PPS) as a way to ensure the efficient delivery of home care services.

IV. President's FY98 Budget Proposal

The provisions included in the February 11, 1997 draft of the Administration's FY98 budget package would have a dramatic impact upon the delivery of home health care under Medicare. Home care would be subject to a level of cuts which is disproportionate to its share of the Medicare program. Home health comprises 9.6% of total Medicare outlays, but would sustain 13% of the cuts requested by the President. For comparison purposes, skilled nursing facility payments now comprise about 6% of total Medicare outlays, but would sustain 7% of the cuts, which is much closer to its proportion of program outlays.

Beyond the depth of the home care cuts, NAHC has grave concerns about the overall effect of the Administration's budget on the future of the Medicare home health benefit. While the President's proposal puts forth a plan to implement a prospective payment system (PPS) for home care and takes a first step toward providing much-needed respite for informal caregivers of Medicare Alzheimer's victims, draft legislative language reveals proposals that would create two separate home care benefits under Part A and Part B of Medicare, impose arbitrary limits on home care and reverse hard-won legal battles which broadened availability of home care to deserving beneficiaries. Additionally, the proposed FY98 budget would grant broad Secretarial authority to deny payment for services which lie outside "norms of care" and to lump post-acute services into a single care payment.

Despite some benefit expansions, the proposed budget translates into very real reductions in access to home care services for needy Medicare beneficiaries.

Transferring Some Home Health Coverage From Part A to Part B of Medicare

Under the President's proposal, Part A would cover home health services only when both of the following conditions are met: (1) home health services are furnished to an individual under a plan of treatment established when the individual was an inpatient of a hospital or rural primary care hospital for not less than three consecutive days before discharge, or during a covered post-hospital extended care stay, and (2) the home health services are initiated for such individual within 30 days after discharge from the hospital, rural primary care hospital, or extended care facility.

All other home health care services—including services not following a hospitalization and services beyond 100 visits—would be covered under Part B.

The additional home care costs transferred into Part B would not be used in calculating the Part B premium, which traditionally covers 25% of Part B program costs. Individuals who have Part A coverage only would continue to have all their home care services covered by Part A until 19 months after the date of enactment.

The National Association for Home Care is opposed to this transfer. NAHC greatly appreciates your leadership, Mr. Chairman, as well as the support from other Members of this Committee, for maintaining home care as a Part A benefit.

This proposal would do little to address the underlying insolvency issues facing the Part A trust fund. We are deeply concerned that this proposed shift will result in increased tax burdens on middle income families and increased costs to Medicare beneficiaries, and may deny needed home care services to millions of seniors and disabled individuals.

This shift would transfer up to $82 billion in costs directly onto taxpayers. The size of the increased burden on taxpayers resulting from this transfer would continue to rise over the years.

If Medicare beneficiaries were required to contribute to the costs of home care transferred to Part B, premiums have been estimated to increase by nearly 20 percent—$8.50 per month in 1998, rising to $11.00 per month by 2002. The Part B monthly premium is already $43.80.

This transfer may also make the home care benefit more susceptible to beneficiary copays and deductibles. As a result, Medicare home health beneficiaries could be subjected to additional coverage restrictions that would further reduce the benefit. This proposal would decrease cost-effective medical benefits to millions of Americans at a time when the need for home care services is growing.

We are additionally concerned that 2.1 million elderly and disabled Medicare beneficiaries who are covered by Part A, but not by Part B, may lose access to much of the Medicare home care benefit under the President's proposal. Beginning 19 months after enactment, the benefit for these individuals would be limited to only 100 visits and only if the care began immediately following a hospital stay of at least three days or discharge from a covered extended care facility. To the extent that these individuals are either already Medicaid eligible, or would spend down to Medicaid due to increased health care costs, this provision would result in an increased burden on State Medicaid programs.

NAHC proposes, instead, fundamentally improving the way Medicare pays for home care services by enacting a prospective payment system (PPS) for home care.

PPS For Home Care

The Administration's PPS proposal included in the Fy98 budget submission falls short of the industry's expectations in a number of ways.

The interim payment proposal essentially continues the present cost-based reimbursement system, while eliminating any savings sharing payments that give providers incentives to reduce costs and increase efficiency. Both the Administration's previous plan, as well as HR 2491 (the Congressionally passed plan) and HR 2530 (the Democratic alternative) contained such incentives for providers. With the retention of cost reimbursement and the elimination of the bonus provisions, this plan contains little by way of incentives for providers to participate in creating more efficient operations.

The interim system would also delay the implementation of blended limits for three months. Totally agency-specific limits tend to maintain previous behaviors, both good and bad. This delay would penalize the most efficient providers.

The Administration's plan also calls for the collection of data to develop a reliable case mix adjuster. While clearly necessary, this provision would result in substantial additional costs to agencies. The cost of this new data gathering requirement should be fully reflected in reimbursement rates under this system.

The Administration's PPS plan has serious flaws, as well. Under this plan, the prospective payment system is to be devised by the Secretary without Congressional oversight or participation by industry or consumer groups. The Administration would also reduce home health cost limits and per-beneficiary limits by 15%, prior to implementation of PPS. This reduction is onerous and unnecessary under PPS.

Interim Payment for Home Health Services

This provision delays updates in the Medicare cost limits from July 1, 1997, to October 1, 1997. As of October 1, 1997, the cost limits would be calculated on the basis of 105% of the median of the labor-related and nonlabor per-visit cost for free-standing home health agencies. Currently, cost limits are calculated on the basis of 112% of the mean. The standard of 105% of median is the effective equivalent of approximately 97% of the mean.

A reduction of the cost limits to 105% of the median is estimated to affect the limits by approximately $10.00 per visit for skilled services and nearly $5.00 per visit for home health aide services. This amendment combined with the disregard of two years of cost increases under the section that maintains the savings from the freeze (discussed below), would reduce the cost limits by approximately 17%.

The delay in cost limit updates could provide a benefit to providers of services having cost reporting periods beginning between July 1 and September 30. These providers would maintain the same higher level of cost limits than would be calculated under the revision for a period of two years, while providers of services with fiscal years beginning on or after October 1 would be subject to a precipitous drop in allowable reimbursement.

The savings resulting from the freeze and the interim payment system would be unnecessary if the industry's Revised Unified Plan for Prospective Payment were adopted by the Congress. While the industry's plan would reduce per-visit payment, it gives providers a more important incentive to reduce overall case costs by restraining the growth in the utilization of services per patient.

PPS would achieve reasonable payment reform and associated budget savings without dramatic reductions in the unit of payment. With the current high degree of federal regulation of home health services, it is difficult and sometimes impossible for a home health agency to initiate large cost reductions with little or no notice. The proposed cost limit reductions ultimately carry the risk that quality of care and access to services may be jeopardized.

Maintaining Savings Resulting From Temporary Freeze on Payment Increases for Home Health Services

This provision in the President's package requires the Secretary to disregard increases in the cost of providing home health care which occurred between July 1, 1994, and July 1, 1996, in updating the home health cost limits after September 30, 1997. The purpose of this provision is to recapture the savings which the program would have incurred if the two-year freeze, which was lifted on July 1, 1996, had been continued. The proposal also limits the Secretary's authority to consider cost changes during the two year period when determining whether a home health agency is entitled to an exemption or exception from the cost limits.

This provision would significantly reduce the current Medicare cost limits. Those limits, implemented with cost report years beginning July 1, 1996, represented the first increase in the limits for home health agencies since July 1, 1993. The reduction in the cost limits through this provision would approximate $7.00 per visit or 7% of the limits. As a result, a significant percentage of home health agencies would provide services at costs above the limit, receiving less reimbursement than the cost of providing the care.

As mentioned earlier, the impact of this provision is magnified when combined with other sections in the President's budget proposal, including the section on interim payment methodology, which further reduce the cost limits for all home health agencies.

Clarification of Part-time or Intermittent Nursing Care

This amendment modifies two provisions of Medicare law which affect the eligibility of beneficiaries for home health services coverage and the level of coverage available. With respect to the test to qualify for home health services coverage, current law requires that the Medicare beneficiary demonstrate a need for skilled nursing care on an intermittent basis or physical or speech therapy.

The provision would restrict Medicare home health eligibility and coverage beyond that available under current law. The existing interpretation of "part-time or intermittent" is the result of a 1988 class action lawsuit which invalidated restrictions on daily, part-time care.

The President's proposal defines "intermittent" as skilled nursing care that is either provided or needed on fewer than seven (7) days each week or less than eight (8) hours of each day of skilled nursing and home health services combined for periods of twenty-one (21) days or less with certain exceptions. At present, there is no definition of "intermittent" contained within existing statute or regulations.

With respect to the level of coverage available for a qualified Medicare beneficiary, current law limits coverage of skilled nursing care and home health aide services to care which is "part-time or intermittent." This amendment proposes to define "part-time or intermittent" services as a combination of skilled nursing and home health aide services furnished less than eight (8) hours each day and thirty-five (35) or fewer hours per week. There is no existing statutory or regulatory definition of this term.

The proposed definition of "part-time or intermittent services" eliminates an important protection which allows for coverage beyond thirty-five (35) hours per week under exceptional circumstances when the need for the additional care is finite and predictable. This component of the definition allows for short term extended hour coverage for individuals such as those awaiting placement in a skilled nursing facility where no bed was available and those patients with a short term acute episode

of care which could be reasonably provided at home, avoiding institutional placement in a hospital or nursing facility.

The proposed definition of "intermittent" used to qualify a Medicare patient for home health services also adds new restrictions. While existing law requires the patient demonstrate a need for intermittent skilled nursing care, the proposed definition of "intermittent" combines skilled nursing and other home health services in determining whether the "intermittent" skilled nursing care requirement has been met. This would exclude eligibility for some patients who currently qualify for Medicare home health services coverage.

For example, an individual that receives daily home health aide services from unpaid caregivers, such as family members, while receiving Medicare covered weekly skilled nursing care would be entirely disqualified from Medicare coverage. Even if this definition were limited to the combination of skilled nursing and other home health services provided by a home health agency, currently eligible Medicare beneficiaries would be denied coverage. To amend the Medicare Act as proposed would not result in a clarification of these terms. Instead, it would result in a reduction in benefits to Medicare beneficiaries.

Definition of Homebound

This amendment establishes new criteria for determining whether an individual's absences from the home demonstrate that the Medicare beneficiary fails to meet the "confined to home" standard. Specifically, the proposal requires that an individual demonstrate the existence of a condition that restricts the ability to leave the home for more than an average of 10 to 16 hours per calendar month for purposes other than to receive medical treatment that cannot be provided in the home.

The proposal further defines existing terms of "infrequent" to mean an average of five or fewer absences per calendar month and "short duration" to mean absences of three or fewer hours on average per absence. Current law allows for nonmedical absences which are infrequent or of short duration. Medically-related absences for treatment that cannot be furnished in the home do not affect an individual's homebound status.

This proposal would add to the confusion surrounding application of the homebound criteria. Under the proposal, several plausible interpretations may be possible. For example, while the existing law allows for absences which are either infrequent or of short duration, the proposal referencing absences averaging 10 to 16 hours per month may be interpreted to combine these two limitations. At the same time, the 10 to 16 hour reference may be interpreted in a manner which indicates that the restrictions for leaving the home begin only after that number of hours since the word "restricts" is not the equivalent of "prevents."

Home care agencies and patients are likely to have great difficulty in dealing with the allowance for medical absences in demonstrating that the treatment "cannot be furnished in the home." Currently, for example, most medically-related treatments can be provided in the home. A home visit by a treating physician can often adequately meet a patient's needs. However, physician services are not generally accessible in the home.

Many current Medicare beneficiaries, especially disabled patients, may be disqualified from Medicare home health services coverage under this provision. In addition, rather than adding clarity to a confusing area, it only adds to the difficulty in interpretation and application through the addition of new terms subject to dispute.

Individuals that attend adult day care, at no expense to the Medicare program, through the use of specialized transportation should not be disqualified because absences are more frequent than five per calendar month or three hours per absence. These individuals generally cannot receive the necessary health care services outside the home and are utterly homebound in the absence in the specialized transportation. Likewise, disabled individuals who are bedbound without the assistance of home health staff should not be disqualified where specialized equipment allow these individuals to leave the home for education, employment, or other purposes. Disqualifying these individuals due to their absences eliminates the availability of essential services which create the opportunity for absences. Many disabled individuals are bedbound unless home health services are provided.

Normative Standards for Home Health Claims Denials

This provision provides authority for the Secretary to deny the frequency and duration of home health services where that care is "in excess of such normative guidelines as the Secretary shall by regulation establish." This provision allows the Medicare program to utilize norms of care for eliminating coverage to individuals.

The Medicare program's practice of using norms of care was outlawed under a settlement agreement in the national class action Duggan v. Bowen in 1989. Under that settlement, the Medicare program is required to render individualized claim determinations which respect a particular Medicare beneficiary's illness, condition, and need for treatment. At that time, it was recognized by the Medicare program that the determination as to the level of care which was reasonable and necessary could only be rendered through an individualized review of that patient's circumstances.

This provision should be rejected. The federal government should not attempt to micro-manage how much and what types of home care services each patient can receive. PPS for home care will provide prudent payments while letting health care providers determine how best and efficiently to meet patients' needs. A similar approach is used with Medicare hospital services under which a flat payment is made to a facility based upon a patient's diagnosis regardless of whether the patient receives care less than or in excess of the norms. The hospital payment, however, provision provides for an outlier payment to recognize that certain patients reasonably require care beyond normative standards.

Further, the Secretary cannot reasonably and accurately establish normative guidelines for home care. Currently, the Medicare program is developing a case mix adjuster for use in a future PPS. However, that case mix adjuster, while categorizing patients, is expected to allow for flexibility in the provision of services to patients within the respective categories.

The use of norms implies an average amount of care for patients within set criteria. Averages cannot be used to deny coverage to individuals since the averages are made up of a range of care needs of specific patients. This proposal will guarantee that many individuals who need home health services would be denied Medicare coverage.

The implementation of this provision will also lead to an endless series of disputes, including litigation, as to the accuracy and objectivity of the calculated norm of care for the particular category of patient. In the end, this provision will be costly to administer, creating harm to Medicare beneficiaries, leading to increased health care costs for under served patients, and restricting coverage to individuals currently entitled under Medicare law.

Development and Implementation of Integrated Payment System for Post Acute Services

This provision authorizes the Secretary to establish an integrated payment system for post acute services furnished by skilled nursing facilities, home health agencies, rehabilitation hospitals, long term care hospitals or such other entities as the Secretary deems appropriate. The payment system may include a single prospective pay rate for all services or a limit on the amounts payable to individual providers or to a single entity.

In establishing the payment system, the Secretary must consider equitable payments across provider types, case mix adjustments, geographic variation, and outlier payments. The Secretary must establish the system to be budget neutral. The system must include quality assurance and monitoring. Finally, the Secretary is authorized to require providers of services to supply the necessary data and other information necessary for implementation, including the development of a standardized core patient assessment instrument.

The authority of the Secretary to implement an integrated payment system for post-acute services does not apply to payments for services furnished before 2002.

NAHC opposes combining, or bundling, home care payments with payments to other providers. Congress should, instead, enact separate prospective payment systems for home care and other post-acute care providers.

Congress should also rebase the hospital DRGs to reflect shorter lengths of stay that have occurred under the hospital PPS.

Nearly half (41%) of all home care patients are now able to receive care and treatment at home from the onset of their illness, avoiding hospitalizations altogether. According to the Prospective Payment Assessment Commission's (ProPAC) June 1996 report to Congress, patients in other post-acute settings were usually discharged from acute care hospitals, but only 59% of all home health episodes were preceded by a Medicare-covered hospital stay.

Bundling would vastly increase Medicare's administrative complexity and the cost of providing home care services by requiring multiple payment systems for home care—one for post-acute patients and one for other home care patients.

User Fees

The Administration would allow States to impose user fees on providers for initial surveys needed for participation in the Medicare program. NAHC opposes user fees and recommends that Congress ensure sufficient funds to cover the costs for survey and certification activities without imposing additional fees on providers.

For the past several years, HCFA's funding for survey and certification activities has been insufficient to complete the level of reviews mandated by Congress. As a result, many state survey agencies were unable to conduct initial surveys of new providers in a timely manner. Providers in these states, therefore, are experiencing long delays in receiving Medicare certification.

The fiscal year 1996 budget (P.L. 104–134) contained a provision designed to provide HCFA the budget flexibility to begin to alleviate the backlog of initial certifications. The legislation increased the time between home health recertifications from once every 12 months to once every 36 months and expanded HCFA's authority to deem agencies as certified if the agencies are accredited by certain private accrediting bodies. In addition, Congress appropriated an additional $10 million over FY96 levels for survey and certification activities in FY97.

Despite these legislative efforts, backlogs for initial surveys in some states still exist. The Administration's proposal would allow states to impose user fees on providers who wish to pay for their initial surveys. In addition, the President's budget reduces the appropriation request for survey and certification by $10 million. The Administration estimates that this $10 million reduction will be made up from user fees, thereby keeping the funding for survey and certification activities at FY97 levels.

User fees are a tax on new providers for participating in the Medicare program. Asking health care providers to provide quality care while at the same time asking them to shoulder both government costs and their own expenses related to the Medicare program is unfair. Moreover, while the proposal imposes user fees only on initial surveys, some existing providers may also be subject to this "tax." For example, home health agencies who wish to open a hospice would be subject to the fee for the hospice's initial survey. In addition, HCFA's recent reclassification of some home health branch offices as subunits would also require initial surveys be conducted for those reclassified facilities.

Fraud and Abuse

The President's budget proposal calls for the repeal of advisory opinions, the exception to anti-kickback penalties for risk-sharing arrangements, and the clarification concerning levels of knowledge required for imposition of civil monetary penalties.

NAHC opposes repeal of these important provider guidance provisions contained in the Health Insurance Portability and Accountability Act (P.L. 104–191).

The Health Insurance Portability and Affordability Act of 1996 put in place a broad based anti-fraud package that balances increased enforcement tools with opportunities for provider guidance. The fraud and abuse legislation established a criminal health fraud statute and increased civil monetary penalties. At the same time, the legislation clarified existing law, created a safe harbor exception for certain risk-sharing arrangements and allowed providers to request advisory opinions from the Department of Health and Human Services (HHS).

The health insurance reform law reflected an effort to balance increased enforcement tools with greater opportunities for guidance and clarification of areas that have previously led to confusion and unintended consequences for providers. Provisions such as the establishment of advisory opinions will assist home care and hospice providers in ensuring that they remain in compliance with health care statutes and regulations. Without these provisions, new criminal sanctions and increased civil monetary penalties may be imposed on home health and hospice providers without adequate opportunities for guidance or clarification of existing law.

Site of Service

The intent of this section in the President's proposal is to ensure that Medicare payments for home care more closely reflect the costs of care in the place where the care is given, the patient's home, rather than the site of the home health agency office.

This section would address this issue in two ways: It may require home health agencies to submit each claim to the fiscal intermediary (FI) that covers the patient's home, rather than submitting all claims to the FI that covers the agency office location, or to require information on the patient's location to be included in the claim. It may also require that the labor costs associated with the area in which

each patient receives home care, rather than the agency office, be used in calculating Medicare payment limits for home care services.

NAHC supports this section, with two significant changes.

First, the section should be rewritten to clarify its intent and to amend Section 1815, rather than Section 1891, of the Social Security Act.

Section 1891 of the Social Security Act sets out requirements to assure home health quality, such as patient rights, training and competency testing of home health aides, and quality surveys and sanctions for home health agencies found to be out of compliance with the quality measures of Section 1891.

The President's proposal would require quality surveyors to begin examining claims forms to find that they match with the correct FI for each patient's area. Quality surveyors are already sorely overworked and underfunded. This non-quality specific requirement would detract from their ability to devote their efforts to ensuring high quality standards in all home health agencies.

This section should be moved to Section 1815 of the Social Security Act, which sets out requirements that providers must meet in order to receive payments under the Medicare program.

Second, home care payments should reflect the labor costs for activities performed both in the patient's location and in the home office area. The Administration's proposal would only recognize the varying labor costs that occur specific to the site of care. Billings, clerk functions, and other activities that are carried out in the agency office should reflect the costs of labor in the office location.

Respite

The President's budget proposal would establish a new respite benefit for the families of Medicare beneficiaries with Alzheimer's disease or other irreversible dementias, beginning in FY98. The benefit would cover up to 32 hours of care per year and would be administered through home health agencies or other entities, as determined by the Secretary of HHS.

Payments would be made at a rate of $7.50 per hour for 1998 and at a rate to be determined by the Secretary in subsequent years. Total payment to the agency or organization furnishing respite services could not exceed 110 percent of the hourly respite allowance times the number of hours of respite for which the agency authorizes payment.

Beneficiaries eligible for this benefit must be severely impaired due to irreversible dementia and need assistance in at least one of five activities of daily living (bathing, dressing, transferring, toileting and eating) or in at least one out of four instrumental activities of daily living (meal preparation, medication management, money management, and telephoning), or needs constant supervision because of a behavioral problem.

Families would be allowed to designate a respite services caregiver through a home health agency or other organization designated by the Secretary. The patient could not be charged more than $2.00 in excess of the hourly rates established by the legislation.

Respite aides may be nurse aides, home health aides, or other individuals licensed by the State or recognized by the Secretary as having the skills necessary to provide such services.

NAHC is pleased that the Administration has proposed a modest beginning in addressing this unmet need. Nearly three-quarters of non-institutionalized disabled elderly persons rely solely on care by friends and family; only 5% receive all of their care from paid sources.

While the respite provision is a step in the right direction, it provides for too few hours and the rates of reimbursement are inadequately low. Payment rates should reflect variation in costs by geographic region and should be adequate to both attract qualified respite aides and pay for their training and supervision. The legislation should also mandate that the Secretary develop competency standards for respite aides.

The availability of respite care can mean the difference between continuation of in-home care and institutionalization. Experience with the implementation of even a small scale respite benefit can provide critical information about issues such as administration, appropriate eligibility criteria and quality assurance. This information will be essential to the future development of a more comprehensive benefit.

Ultimately, Congress should include in-home respite care in the Medicare home health benefit. Eligibility should be based on a broader definition of functional and cognitive impairments.

Elimination of Periodic Interim Payments for Home Health Agencies

This proposal eliminates the availability of a longstanding method of payment for home health agencies known as Periodic Interim Payments (PIP), effective with the initiation of a proposed prospective payment system (PPS) on October 1, 1999.

PIP is a system which projects an agency's expected Medicare home health payments and provides biweekly reimbursement to the agency based upon that projection. Under PIP, adjustments for underpayments and overpayments are made throughout the fiscal year in order to achieve reimbursement consistent with total amount owed by the end of the fiscal year.

Periodic Interim Payments have been essential for many home health agencies in order to maintain an appropriate cash flow to meet the labor-intensive cost of delivering home health services. Unlike many other health care providers, such as hospitals and nursing facilities, home health agencies do not have ready access to capital or credit due to a lack of profits through cost reimbursement and limited capital equity. PIP has helped providers avoid interest costs and revenue shortfalls which could jeopardize the continued delivery of services to patients.

The industry has expressed a willingness to accept the elimination of PIP corresponding with the implementation of the industry's PPS plan. The Administration's proposal however, while eliminating PIP at the implementation of PPS, does not provide the type of interim PPS system proposed by the industry which would allow for home health agencies to build capital pending the transition to PPS. NAHC recommends that PIP, in this case, be eliminated twelve months after the implementation of episodic PPS.

Payment Under Part B

This section amends Section 1833(a)(2) of the Social Security Act, conforming payments for Medicare Part B home health services to the amended cost limit provision and interim payment methodology set out in the President's package. In addition, it has the effect of eliminating the lower of cost or charges principle from the determination of rates of payment. Currently, Medicare limits reimbursement to home health agencies based on the lower of its costs or charges. This proposal will continue an exemption from the lower cost or charges principle for certain public providers that offer services at a nominal charge.

While the provision appropriately modifies Part B payment structures to conform with the overall payment reform measures affecting home health services under Medicare, it may have inadvertently eliminated application of the lower of cost or charges principle. The NAHC supports the elimination of the lower cost or charges rule (LCC). However here, the proposed action eliminates LCC only for Part B and not for Part A.

V. Other Issues of Importance to Home Care

Waiver of Liability

Also included in the BBA and closely linked to enactment of PPS was a provision to extend the presumptive status of the waiver of liability for home care, a provision of great importance to NAHC.

In 1972 the Health Care Financing Administration created a presumptive waiver of liability status for Medicare providers. Under the presumptive waiver, providers were presumed to have acted in good faith and were paid for services to a Medicare patient if their low error rate demonstrated a reasonable knowledge of coverage standards in their submission of bills. The presumptive waiver was later incorporated into legislation which after several extensions expired for home care and hospice on December 31, 1995.

The BBA would have extended the presumptive waiver for home care until October 1, 1996, when the Act provided that a prospective payment system would be established for home care. When the Act was vetoed, the presumptive status of the waiver expired.

To make matters worse, HCFA has imposed a system which presumes fraud by assuming providers knew their claims would not be covered, forcing providers to appeal each claim. Reconsideration of claims costs the federal government approximately $400 per claim, and costs providers in the range of $150 for each claim, just to reach the point of requesting waiver protection. If the dispute moves to the Administrative Law Judge level, the federal government and the provider each incur likely costs of $1,000 per claim reviewed.

In order for a home care agency to be compensated under the waiver presumption, its overall denial of claims rate had to be less than 2.5% of the Medicare services provided. Any agency that exceeded this limit was not reimbursed under the pre-

sumptive waiver. This requirement forced agencies to use due diligence in determining eligibility and coverage.

Given the vague application of constantly changing regulations, guidelines, and directives, it is difficult enough for home health agencies to be 97.5% correct in their determinations of eligibility. The high number of claims denials that are reversed (25% at reconsideration stage and 70% at the Administrative Law Judge level) shows that coverage decisions are not as clear cut as HCFA asserts. At a time when sicker patients are admitted to home care following earlier hospital discharges, coverage questions are more complex, and the buffer zone of the waiver presumption is particularly important.

Congress enacted the presumptive waiver to encourage home health agencies to provide services to Medicare patients, and to save on the considerable administrative time and expense of handling appeals in cases where agencies are delivering services in the good faith belief that the services are covered by Medicare. In the absence of the waiver presumption, agencies will have no recourse but to reject clients if there are any doubts about coverage. The waiver presumption for home health agencies and hospices should be permanently reinstated and made retroactive to January 1, 1996.

We want to thank you, Mr. Chairman, and Members of this Committee for your past support of the extension of the presumptive waiver in the budget reconciliation package that was reported out of the Committee in the 104th Congress. We would like to extend a special thanks to Representatives Johnson and Kennelly, for their advocacy in behalf of extending the waiver.

Copays

We are gratified that the President's FY98 budget proposal does not include the imposition of copayments on Medicare home health services. Imposition of a home health copayment would create a new "sick" tax on the most frail and vulnerable elderly and disabled Americans—those who could least likely afford it. Moreover, the policy is "penny wise and pound foolish" and may end up costing the Medicare program more since patients who cannot afford the copayment may defer necessary services, resulting in subsequent nursing home placements, hospitalization or care from other more costly institutions.

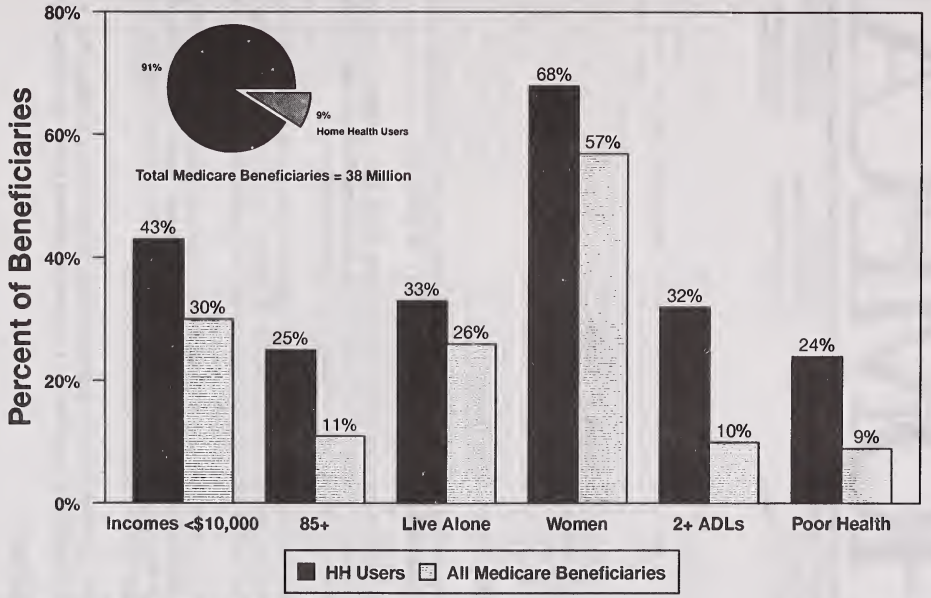
Medicare home health copayments do not take into account the in-kind contributions made by Medicare home care patients toward the cost of their care. When Medicare pays for the care of an individual in a nursing home or hospital, it also pays its share of the cost of the building, maintenance, overhead, food, heat, and other significant costs, none of which Medicare incurs with home care. In addition, home care patients, families, and friends make significant contributions to care through "sweat equity." Individuals who receive no Medicare reimbursement provide significant care to Medicare home care patients, as home care nurses train family members and friends to provide care at home.

When the home health benefit was first enacted in 1965, it contained a copayment requirement. This copayment was later dropped because it cost Medicare more to collect in administrative costs than it saved the program. Copayments were a bad idea then, they are a bad idea now.

Conclusion

Thank you again, Mr. Chairman, for the opportunity to present our views. Home care has waited for many years to get to this point in the development and consideration of a prospective payment system for home care. You and the Committee have our thanks for bringing the issue to this level of consideration and we look forward to working closely with you in bringing PPS to enactment and on the other important issues facing home care this year.

Characteristics of Medicare Home Health Users



Source: HCFA, 1994 Medicare Current Beneficiary Survey

HOMECARE

NATIONAL ASSOCIATION FOR HOME CARE
228 Seventh Street, SE
Washington, DC 20003
202/547-7424, 202/547-3540 fax

February 28, 1997

The Honorable William M. Thomas
U.S. House of Representatives
2208 Rayburn House Office Building
Washington, D.C. 20515

Dear Representative Thomas:

The undersigned state home care associations urge you to oppose any attempt to shift funding for home health care from Part A to Part B of Medicare.

Home care provides a wide range of vital health care services for 3.5 million elderly and disabled Americans. The Medicare home health benefit allows these individuals to remain in their own homes, often avoiding more costly hospitalizations.

Shifting partial funding for the benefit from Part A to Part B of Medicare would not achieve true savings toward reducing the federal deficit, nor would it address the underlying issues surrounding the impending insolvency of the Hospital Insurance (Part A) Trust Fund.

The A to B shift may also make home care more susceptible to Part B copays, which are extremely regressive, as well as attempts to "bundle" home care payments with hospital DRGs or with other post-acute provider payments. The proposal could also result in tremendous increases in Medicare administrative costs.

We urge your support of maintaining home health care as a Medicare Part A benefit, as well as your support for enactment of a prospective payment system for Medicare home care.

Sincerely,

The Undersigned Members of
The National Association for Home Care Forum of State Associations

HOMECARE

Forum of State Associations A to B Letter

Alabama Association of Home Health Agencies
Alaska Home Care Association
Arizona Association for Home Care
Home Care Association of Arkansas
Home Care and Hospice Assn of California
California Assn for Health Services at Home
Home Care Association of Colorado
Connecticut Association for Home Care
Delaware Assn for Home & Community Care
Capital Homecare Association
Associated Home Health Industries of Florida
Georgia Association of Home Health Agencies
Georgia Assn of Community Care Providers
Georgia Staffing and Home Care Association
Hawaii Association for Home Care
Idaho Association of Home Health Agencies
Illinois Home Care Council
Indiana Association for Home Care
Iowa Association for Home Care
Kansas Home Care Association
Kentucky Home Health Association
HomeCare Association of Louisiana
Home Care Alliance of Maine
Maryland Association for Home Care
Home & Health Care Assn of Massachusetts
MA Council for Home Care Aide Services
Michigan Home Health Association
Minnesota HomeCare Association
Mississippi Association for Home Care
Missouri Alliance for Home Care
Montana Association of Home Health Agencies
NE Assn of Home & Community Health Agencies
Home Health Care Association of Nevada
Home Care Association of New Hampshire
Home Health Assembly of New Jersey, Inc.
Home Care Council of New Jersey
Home Health Services & Staffing Assn of NJ
New Mexico Association for Home Care
Home Care Association of New York State
New York State Assn of Health Care Providers
North Carolina Association for Home Care
North Dakota Assn of Home Health Services
Ohio Council for Home Care
Oklahoma Association for Home Care
Oregon Association for Home Care
Pennsylvania Assn of Home Health Agencies
PR Home Health Agencies and Hospice Assn
Rhode Island Partnership for Home Care
Rhode Island Visiting Nurses Network
South Carolina Home Care Association
South Dakota Home Health Association
Tennessee Association for Home Care
Texas Association for Home Care
Utah Association of Home Health Agencies
Vermont Assembly of Home Health Agencies
Virginia Association for Home Care
Home Care Association of Washington
West Virginia Council of Home Health Agencies
Wisconsin Homecare Organization
Home Health Care Alliance of Wyoming

Revised Unified Proposal for a
Prospective Payment System for Medicare Home Health Services

March 28, 1996

Attached is the Industry's Unified Plan for Prospective Payment System (PPS) for Medicare Home Health Services. It was developed jointly by the National Association for Home Care (NAHC) and the PPS Work Group.

This plan is a modification of the original unified plan submitted to Congress in 1995 as an alternative to Congressional movement to impose copays on Medicare home care services or to bundle home care payments into payments to hospitals. The modifications were made to the original proposal to respond to concerns about implementation feasibility raised by HCFA.

This plan incorporates the best elements of the home care PPS provisions in HR 2491 passed by Congress and HR 2530. It represents months of work and refinement by the home care industry. The plan calls for a three–phase approach to achieving episodic PPS. It starts with an interim PPS plan that utilizes existing data and processes and moves to an episodic PPS with a refined case mix adjuster.

PPS is a more efficient, cost–effective alternative for achieving reductions in the growth of expenditures than copays or bundling of home care services. PPS can accomplish this goal without jeopardizing beneficiary health and safety, or increasing out–of–pocket costs.

We invite your careful review of this proposal. If you have any questions or would like additional information please feel free to contact any of our organizations at the numbers listed below.

National Association for Home Care
Dayle Berke/Lucia DiVenere 202–547–7424

PPS Work Group
Jim Pyles 202–466–6550

Home Care's Plan to Implement Prospective Payment for Medicare Home Health Services

I. Home Care's Goal

The goal of the home care provider community is to manage the growth of Medicare home health expenditures in a manner that promotes efficiency and preserves access to quality care for Medicare beneficiaries. This will be accomplished through the development and implementation of an episodic prospective payment system as soon as feasible. PPS is a more efficient, cost–effective alternative for achieving reductions in the growth of expenditures than copays or bundling of home care services. PPS can accomplish this goal without jeopardizing beneficiary health and safety.

PPS will be phased in over time, culminating in an episodic prospective payment system plan that should:

- be developed cooperatively by HHS, the industry, and Congress
- be acceptable to the industry
- include extended care
- be submitted to Congress one year in advance of implementation, and within 4 years of enactment of legislation
- be approved by Congress
- include adjustments for new requirements (such as OSHA) or changes in technology or care practices
- be based on a case mix adjustor that reflects the differences in cost for different types of patients

II. An Interim PPS Plan

An interim PPS plan incorporating certain elements of the Congressional and Democratic proposals (HR 2491 and HR 2530) should be implemented commencing within 6 months of enactment and continue until it can be converted to a pure episodic prospective payment system (Phase III). The interim PPS plan should be based on the industry's design and set forth in legislative language. The interim plan is implemented in phases to provide HCFA sufficient time to collect necessary data and to develop required processes and procedures. Current coverage criteria for Medicare home health services should be maintained and no coverage shifted to Part B.

III. Time Line for PPS Phase-In

Enact Legis.	Begin Data Collec	Begin Phase I Interim PPS	Begin Phase II Interim PPS	Report to Congress on Episodic PPS	Expected Implementation Phase III Episodic PPS
0	2mo	6mo	24mo –30mo	48mo	60mo

IV. PPS SPECIFICATIONS

A. Data Collection

HCFA is mandated to begin immediately to develop a data base upon which a fair and accurate case mix adjustor can be developed and implemented. The data base must be able to link case mix data with cost (and utilization) data.

The data base must include a sample sufficiently large to support the development of statistically valid estimates of payment rates and limits for the geographic area used (e.g., MSA/nonMSA, national, census region).

The data base must contain at least:

- items for the 18 category Phase II case mix adjustor
- HCFA form 485
- UB–92
- additional data items that may contribute to a more accurate case mix system, developed with industry participation (such as items from OASIS)

Payment rates and limits shall be adjusted to reflect cost of data collection

Effective date: 60 days after enactment

B. Phase-In of PPS Beginning with the Interim Plan

Phase I

Prospectively set standard per visit payment (as in HR 2491) with an annual aggregate per patient limit that applies to all visits (as in HR 2530)

Effective date: 6 months after enactment

All currently allowable costs related to nonroutine medical supplies will be included in the data base for calculating the per visit rate, per visit limit, and aggregate limits.

Per visit payment

- o standard per visit rate for each discipline calculated (as in HR 2491) as follows:

  the national average amount paid per visit under Medicare to home health agencies for each discipline during the most recent 12 month cost reporting period ending on or before 12–31–94 and updated by the home health market basket index, except that the labor–related portion of such rate shall be adjusted by the area wage index applicable under section 1886(d)(3)(E) for the area in which the agency is located

- o amounts in excess of the per visit rate, up to a limit as defined below, may be paid if:
  1) an HHA can demonstrate costs above the payment rate, and
  2) quarterly reports demonstrate that total payments will not exceed the agency aggregate limit

- o the payment rates and limits are calculated initially from the base year costs and cost limits and updated by the home health market basket index to the date of implementation; they are updated annually by the market basket index

- o base year for payment rates and cost limits – 1994 (using settled cost reports)

Agency annual aggregate per patient payment limit

- o base year for aggregate payment limit – 1995 utilization data for each agency

- o the blended annual per patient limit is based on the reasonable cost per unduplicated patient in the base year (1994 cost per visit–updated, multiplied by 1995 utilization) and updated by the home health market basket index; calculation based 75% on agency data & 25% on census region data for 12 months following implementation of Phase I, then 50% agency data & 50% census region data

- o the blended annual aggregate per patient limit is equal to the number of unduplicated patients served in the year multiplied by the per patient blended limit

- o census region: the 9 census region geographic areas (New England, Middle Atlantic, East North Central, West North Central, South Atlantic, East South Central, West South Central, Mountain, Pacific)

Sharing Savings

HHAs that are able to keep their total payments for the year below their annual aggregate per patient cap and below 125% of the census region cost/utilization experience shall receive a payment equal to 50% of the difference between the total per visit payments and the agency's aggregate limit. Such payments may not exceed 10% of an agency's aggregate Medicare per visit payments in a year.

- o Phase I in place 18 months (no longer than 24 months)

Phase II

Prospectively set standard per visit payment with an annual aggregate episode limit for days 1–120 (as in HR 2491); and an annual aggregate per patient limit for visits after 120 days

- o continue per visit payment as in Phase I
- o an episode is 120 days; post 120 day care is paid per visit with an annual aggregate per patient blended limit for the post 120 day period that is separate from the 1–120 day annual aggregate episode limit
- o the HHA is credited for a new episode limit if there is a period of 45 days without Medicare covered home health care services following the 120 day episode (if a patient is readmitted before a new episode can be started, the agency is paid per visit subject to the aggregate episode limit if within the first 120 days, or the separate post 120 day aggregate per patient blended limit if after 120 days)
- o the 18 category Phase II case mix adjustor is applied to the first 120 days, or a more accurate one if available
- o the per episode limit (as in HR 2491) is equal to the mean number of visits for each discipline during the 120 day episode of a case mix category in an area during the base year multiplied by the per visit payment rate for each discipline
- o the annual aggregate episode limit (as in HR 2491) is equal to the number of episodes of each case mix category during the fiscal year multiplied by the per episode limit determined for such case mix category for such fiscal year
- o the region for the episode limit – MSA/nonMSA area
- o the annual post 120 day per patient blended limit is based on the reasonable cost per unduplicated patient receiving care beyond 120 days in the base year (1994 cost per visit–updated, multiplied by 1995 utilization) and updated by the home health market basket index; calculation based 50% on agency data & 50% on census region data
- o the annual aggregate post 120 day per patient blended limit is equal to the number of unduplicated patients receiving care beyond 120 days in the year multiplied by the per patient blended limit
- o the current certification and coverage guidelines continue

Sharing Savings

HHAs that are able to keep their total payments for the year below their annual aggregate episode and post 120 day per patient caps; and the post 120 day per patient payments below 125% of the census region cost/utilization experience, shall receive a payment equal to 50% of the difference between the total per visit payments and the agency's aggregate limits. Such payments may not exceed 10% of an agency's aggregate Medicare per visit payments in a year.

Phase III (as noted under the goal in section I)

Per Episode PPS

- o developed cooperatively by HHS, the industry, and Congress
- o acceptable to the industry
- o includes extended care
- o must be submitted to Congress one year in advance of implementation and within 4 years of enactment of legislation
- o approved by Congress
- o adjustments for new requirements (such as OSHA) or changes in technology or care practices
- o case mix adjustor that reflects the differences in cost for different types of patients

C. Additional Specifications that Apply to All Phases

1. **Exceptions:** The Secretary shall provide for an exemption from, or an exception and adjustment to, the methods for determining payment limits where extraordinary circumstances beyond the home health agency's control including outliers and the case mix of such home health agency, create unintended distortions in care requirements not accounted for in the case mix adjustor payment system. The Secretary shall develop a method for monitoring expenditures for such exceptions. Methods should be developed to allow for additional home care expenditures when they are found to decrease total Medicare expenditures.

2. **Quality:** Any prospective payment system must ensure that home health agencies do not seek to become more cost effective by sacrificing quality. The Secretary will ensure that the quality of services remains high by implementing a revised survey and certification process which emphasizes patient satisfaction and successful outcomes.

   Home health agencies will be required to provide covered services to beneficiaries to the extent that those services are determined by the beneficiary's physician to be medically necessary.

   There will be established a means for beneficiary due process to challenge care and coverage determinations first through internal provider grievance procedures, then through external PRO review.

   There will be established a mechanism for quality review for instances of significant variation in utilization by providers. (this can address both visits and admissions)

SPECIAL UPDATE

NAHC Report

National Association for Home Care's Weekly News Source for the Home Care Industry *Number 700a • February 28, 1997*

Administration's FY 98 Budget Cuts Home Health Care by 13%

NAHC Releases Detailed Analysis of Medicare Home Health Provisions

This year the Congress and the Clinton Administration are expected to agree on a fiscal year 1998 (FY 98) spending package that will balance the federal budget by 2002 and lengthen the solvency of the ailing Medicare Hospital Insurance (HI) Trust Fund (Part A), which is currently projected to run out of funds in 2001. Extending the solvency of the Part A fund will provide additional time during which the Congress can debate longer-term solutions for restructuring Medicare.

Against this backdrop, the President submitted his FY 98 budget to the Congress on February 6, 1997. The package is estimated to yield approximately $115 billion in Medicare cuts between 1998 and 2002; $15 billion of the cuts would be offset by increased benefits for Medicare enrollees. The net five-year reduction in Part A outlays is $77.9 billion; Part B net reductions are estimated at $22.3 billion.

The Administration's budget package would have a dramatic impact upon the delivery of home health care under Medicare. Overall, home care would be subject to a level of cuts that is disproportionate to its share of the Medicare program. Home health comprises 9.6% of total Medicare outlays, but would sustain 13% of the cuts requested by the President. For comparison purposes, skilled nursing facility (SNF) payments now comprise about 6% of total Medicare outlays, but would sustain 7% of the cuts, which is much closer to its proportion of program outlays.

Beyond the depth of the home care cuts, the National Association for Home Care (NAHC) has grave concerns about the overall effect of the Administration's budget on the future of the Medicare home health benefit. Although the President's proposal puts forth a plan to implement a prospective payment system (PPS) for home care and takes a first step toward providing much-needed respite for informal caregivers of Medicare Alzheimer's patients, draft legislative language reveals proposals that would create two separate home care benefits under Part A and Part B of Medicare, impose arbitrary limits on home care, and reverse hard-won legal battles that broadened availability of home care to deserving beneficiaries. Additionally, the proposed FY 98 budget would grant broad secretarial authority to deny payment for services that lie outside "norms of care" and to lump post-acute services into a single-care payment.

Despite some benefit expansions, the proposed budget translates into very real reductions in access to home care services for needy Medicare beneficiaries.

This document provides indepth, technical analyses of select, specific provisions of draft legislative language of the President's plan that would affect the home health program, home care beneficiaries, and the home care industry. As updated versions of the legislative language become available, NAHC will provide further analysis.

Section 11246. Respite Benefit

Provision: This section establishes a new respite benefit for the families of Medicare beneficiaries with Alzheimer's disease or other irreversible dementia, beginning FY 98. Medicare beneficiaries would be eligible to receive nonmedical care, giving family members a much-needed break from the constant demands of caregiving. The benefit would cover up to 32 hours of care per year and would be administered through home health agencies or other entities, as determined by the Secretary of Health and Human Services (Secretary). The five-year cost for this proposal is about $2 billion.

Payment would be made at a rate of $7.50 per hour for 1998 and at a rate to be determined by the Secretary in subsequent years. Total payment to the agency or other organization furnishing respite services may not exceed 110% of the hourly respite allowance times the number of hours of respite for which the agency authorizes payment.

A Medicare beneficiary for whom payment is claimed must be severely impaired due to irreversible dementia and need assistance in at least one of five activities of daily living (bathing, dressing, transferring, toileting, and eating) or in at least one out of four instrumental activities of daily living (meal preparation, medication management, money management, and telephoning),

or be in need of constant supervision because of a behavioral problem.

Families select a respite services caregiver through a home health agency or other organization designated by the Secretary. The beneficiary could not be charged more than $2.00 in excess of the hourly rates established by the legislation.

Respite care as temporary care for the purpose of ensuring periodic time off for primary informal caregivers living with the patient. Although respite providers may provide assistance with personal care or household maintenance activities, their primary function would be to provide protective supervision for persons with Alzheimer's and related dementias.

"Respite aides" may be nurse aides, home care aides, or other individuals licensed by the state or recognized by the Secretary as having the skills necessary to provide such services.

NAHC Analysis: NAHC is pleased that the Administration has recognized the enormous burden on caregivers and proposed a modest beginning in addressing this unmet need. Nearly three-quarters of non-institutionalized disabled elderly persons rely solely on care by friends and family; only 5% receive all of their care from paid sources.

Although the respite provision is a step in the right direction, it provides for too few hours and the rates of reimbursement are inadequate. Payment rates should reflect variation in costs by geographic region and should be adequate to attract qualified respite aides and pay for their training and supervision. The legislation should also mandate that the Secretary develop competency standards for respite aides.

The availability of respite care can mean the difference between continuation of in-home care and institutionalization. Experience with the implementation of even a small-scale respite benefit can provide critical information about issues such as administration, appropriate eligibility criteria, and quality assurance. This information will be essential to the future development of a more comprehensive benefit.

Ultimately, Congress should include in-home respite care in the Medicare home health benefit, as well as enact a long-term respite care program outside the Medicare program. Eligibility should be based on a broader definition of functional and cognitive impairments.

Section 11271.Maintaining Savings Resulting From Temporary Freeze on Payment Increases for Home Health Services

Provision: This provision requires the Secretary to disregard changes in home health costs that occurred between July 1, 1994, and July 1, 1996, in updating the home health cost limits after September 30, 1997. The purpose of this provision is to recapture the savings that the program would have incurred if the two-year freeze, which was lifted on July 1, 1996, had been continued. The proposal also limits the Secretary's authority to consider cost changes during the two-year period when determining whether a home health agency is entitled to an exemption or exception from the cost limits.

NAHC Analysis: This provision would result in a significant reduction in the current Medicare cost limits. Those limits, implemented with cost report years beginning July 1, 1996, represented the first increase in the limits for home health agencies since July 1, 1993. It is anticipated that the reduction in the cost limits through this provision would approximate $7.00 per visit or 7% of the limits. As a result, a significant percentage of home health agencies will provide services at costs above the limit, thereby receiving less reimbursement than the cost of providing the care.

The impact of this provision is increased when combined with section 11272 (following Section), which further reduces the cost limits for home health agencies.

Section 11272(a) and (b). Interim Payment for Home Health Services

Reductions in Cost Limits; Delay in Updates

Provision: This provision, part of the Interim Payment Reform for Medicare home health services, delays updates in the Medicare cost limits from July 1, 1997, to October 1, 1997. As of October 1, 1997, the cost limits would be calculated on the basis of 105% of the median of the labor-related and nonlabor per-visit cost for freestanding home health agencies. Currently, cost limits are calculated on the basis of 112% of the mean. Setting cost limits at 105% of median is effectively equivalent to 97% of the mean.

NAHC Analysis: A reduction of the cost limits to 105% of the median will reduce the limits by approximately $10.00 per visit for skilled services and nearly $5.00 per visit for home care aide services. This amendment combined with the disregard of two years of cost increases under Section 11271 would reduce the cost limits by approximately 17%.

The delay in cost limit updates could provide a windfall to providers of services having cost reporting periods beginning between July 1 and September 30. These providers would maintain the same higher level of cost limits than would be calculated under the revised for a period of two years, while providers of services with fiscal years beginning on or after October 1 would be subject to a precipitous drop in allowable reimbursement.

The changes recommended by Sections 11271 and 11272 would be unnecessary if the industry's revised unified PPS plan for home health

[redacted] Congress. While [redacted] a plan would reduce [redacted] payments, it gives providers a more important incentive to reduce overall cost costs by restraining the growth in the utilization of services per patient. This approach achieves reasonable payment reform without drastic reductions in the unit of payment. With the current high degree of federal regulation of home health services, it is difficult and sometimes impossible for a home health agency to initiate large cost reductions with little or no notice. The proposed cost-limit reductions may [redacted] jeopardize quality of care and access to services.

Section 11272(c). Additions to Cost Limits

Limits for Fiscal Years 1997 Through 1999

Provision: This section sets forth an interim payment system for services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997. This system ends beginning with cost reporting periods that start after October 1, 1999. Payments would be the lesser of Medicare allowable costs, reasonable cost limits (set at 105% of the median), or an agency-specific limit per beneficiary based on the agency's cost per unduplicated beneficiary in a FY 94 base period, updated with the home health market basket index. The agency-specific, per-beneficiary limitation is applied in the aggregate by multiplying the limit by the agency's unduplicated Medicare census count.

[redacted] The proposal essentially continues the present cost-based reimbursement system. It eliminates any chance of savings to providers as incentives for cost effectiveness and [redacted] efficiency. Both the Administration's proposed plan, as well as HR [redacted] that Congress initially passed [redacted] HR 2530 (the Democratic alternative introduced in the 104th Congress), contained such incentives for providers. With the retention of cost reimbursement and the failure to include shared-savings provisions, this plan contains little by way of positive incentives for providers to participate in creating more efficient operations.

The resulting reductions would be significant: cost limits would be reduced by approximately 17% and the overall budget for patient visits would be reduced by approximately 20%.

Special rules

Provision: (I) New providers (without a FY 94 base year) would have per-beneficiary limits equal to the mean of limits applied to home health agencies. New providers do not include agencies that have changed names or corporate structure. (II) Beneficiaries who use services furnished by more than one agency would have the per-beneficiary limits prorated among the agencies.

NAHC Analysis: It is unclear whether the mean of limits used to determine per beneficiary limits for new providers would be a national mean or one applied by area, such as census region. If the mean of limits is intended to be national, this creates the potential for inappropriately high or low limits.

Modifications for Regional or National Variations in Utilization

Provision: As soon as possible, or effective April 1, 1998, the limits would be calculated as a blend of 75% of the agency-specific reasonable cost or utilization experience in the base year and 25% of the national or census region cost or utilization experience, or best estimates.

NAHC Analysis: Implementation of the blended limit is delayed three months after the interim system is [redacted] begun. Use of a [redacted] agency-specific [redacted] the [redacted] previous behaviors, [redacted] bias. This could result in penalizing the most efficient providers.

Section 11272(d). Development of Case-mix System

Provision: Under this provision, the Secretary is required to conduct research necessary to develop a reliable case mix adjuster in order to get to a per-episode PPS system.

Section 11272(e). Submission of Data for Case-mix System

Provision: Home health agencies are required to submit additional information "as the Secretary considers necessary" for the development of a case mix system, effective for cost-reporting periods beginning on or after October 1, 1997.

NAHC Analysis: [redacted] prediction is [redacted] developing a reliable case mix adjuster [redacted] substantial additional costs to agencies. [redacted] reflect the cost of data gathering.

Section 11273. Prospective Payment for Home Health Services

Provisions: A PPS would be implemented by October 1, 1999.

(1) Prospective payment amount

The prospective payment amount would be based on a unit of service and the number of visits provided within that unit. The amount would be based on the most current audited cost report data available.

(2) Use of case mix

A case mix system would be used that explains a significant amount of the variation in cost.

(3)Annual adjustments
Payment amounts would be updated annually by the home health market basket index. The hospital wage index would be used for adjusting the labor-related portion of the payment amount.
(4)Outliers
Payments may be adjusted for unusual variations in the type or amount of care.
(5)Prorating prospective payment amounts
If services are provided by more than one agency, the payment would be prorated between home health agencies.
(6)Savings
Prior to implementing the PPS, the cost limits and per-beneficiary limits in effect on September 30, 1999, would be reduced by 15%.

Section 11274(a) and (b). Payment Based on Location Where Home Health Service Is Furnished

Provision: The intent of this section is to ensure that Medicare payments for home care more closely reflect the costs of care in the place where the care is given, the patient's home, rather than the site of the home health agency office.

It is unclear under subsection (a) whether home health agencies would be required to submit claims to the fiscal intermediary (FI) that covers the patient's home location, rather than submitting all claims to the FI that covers the agency office location or if an agency is just required to include information regarding the patient's location in the claim.

Subsection (b) may require that the labor costs associated with the area in which each patient receives home care, rather than the labor adjustment for the agency office, be used in calculating Medicare payment limits for home care services.

NAHC Analysis: NAHC supports this section, with two significant changes.

First, subsection (a) should be rewritten to clarify its intent to amend Section 1815, rather than Section 1891, of the Social Security Act.

Section 1891 of the Social Security Act sets out requirements to assure home health quality, such as patient rights, training and competency testing of home care aides, quality surveys, and sanctions for home health agencies found to be out of compliance with the quality measures of Section 1891.

Subsection (a) of Section 11274 would require quality surveyors to begin examining claims forms to find that they match with the correct FI for each patient's area. Quality surveyors are already sorely overworked and underfunded. This nonquality-specific requirement would detract from their ability to devote their efforts to ensuring high-quality standards in all home health agencies.

Subsection (a) should be moved to Section 1815 of the Social Security Act, which sets out requirements that providers must meet to receive payments under the Medicare program.

Second, home care payments should reflect the labor costs for activities performed both in the patient's location and in the home office area.

The Administration's proposal would only recognize the varying labor costs that occur specific to the site of care. Billing, clerk functions, and other activities that are carried out in the agency office should reflect the costs of labor in the office location.

Section 11275. Elimination of Periodic Interim Payments for Home Health Agencies

Provision: The proposal eliminates the availability of a longstanding method of payment for home health agencies known as Periodic Interim Payments (PIP), effective with the initiation of a proposed PPS on October 1, 1999. PIP is a system that projects an agency's expected Medicare home health payments and provides biweekly reimbursement to the agency based on that projection. Under PIP, adjustments for underpayments and overpayments are made throughout the fiscal year to achieve reimbursement consistent with total amount owed by the end of the fiscal year.

NAHC Analysis: PIPs have been essential for many home health agencies to maintain an appropriate cash flow to meet the labor-intensive cost of delivering home health services. Unlike many other health care providers, such as hospitals and nursing facilities, home health agencies do not have ready access to capital or credit due to a lack of profits through cost reimbursement and limited capital equity. PIP has helped providers avoid interest costs and revenue shortfalls that could jeopardize the continued delivery of services to patients.

The industry is willing to accept the elimination of PIP corresponding with the implementation of the industry's proposed PPS plan. The Administration's proposal, however, while eliminating PIP at the implementation of PPS, does not provide the type of interim PPS system that would allow home health agencies to build capital pending the transition to PPS. If a PPS plan other than the industry's is enacted, NAHC recommends that PIP be eliminated 12 months after implementation.

Section 11276(a),(b),(c) and (f). Establishment of Post-hospital Home Health Benefit Under Part A and Transfer of Other Home Health Services to Part B

Provisions: Subsections (a), (b), and (c) would continue Part A coverage of home health services only when both of the following conditions are met: (1) home health services are furnished to an individual under a plan of treatment established when the individual was an inpatient of a hospital or rural primary care hospital for not less than three consecutive days before discharge, or during a covered post-hospital extended care stay, and (2) the home health services are initiated for such individual within 30 days after discharge from the hospital, rural primary care hospital, or extended care facility.

All other home health care services—including services not following a hospitalization and services beyond 100 visits—would be covered under Part B.

Subsection (f) requires that the additional home care costs transferred into Part B not be used in calculating the Part B premium, which traditionally covers 25% of Part B program costs.

Subsection (i)(2) allows individuals who have Part A coverage only to continue to have all their home care services covered by Part A until 19 months after date of enactment.

NAHC Analysis: NAHC opposes this transfer. This proposal would do little to address the underlying, long-term insolvency issues facing the Part A trust fund. NAHC is deeply concerned that this proposed shift will result in increased tax burdens on middle-income families and increased costs to Medicare beneficiaries and may deny needed home care services to millions of seniors and disabled individuals.

This shift would transfer up to $82 billion in costs directly onto taxpayers. The size of the increased burden on taxpayers resulting from this transfer would continue to rise over the years.

If Medicare beneficiaries were required to contribute to the costs of home care transferred to Part B premiums have been estimated to increase by nearly 20%—$8.50 per month in 1998, rising to $11.00 per month by 2002. The Part B monthly premium in 1997 is already $43.80.

NAHC is additionally concerned that 2.1 million elderly and disabled Medicare beneficiaries who are covered by Part A, but not by Part B, may lose access to much of the Medicare home care benefit under the President's proposal. Nineteen months following enactment, the benefit for these individuals would be limited to up to 100 visits and only if the care began immediately following a hospital stay of at least three days or discharge from a covered extended care facility. For those individuals who are either already Medicaid eligible, or who would spend down to Medicaid without Medicare home care coverage, this provision would result in a considerable increased burden on state Medicaid programs.

NAHC proposes instead, fundamentally improving the way Medicare pays for home care services by enacting a PPS for home care.

Section 11276(e). Payment Under Part B

Provision: This section amends Section 1833(a)(2) of the Social Security Act, conforming payments for Medicare Part B home health services to the amended cost limit provision and interim payment methodology set out in the President's budget under Sections 11271 and 11272. In addition, it has the effect of eliminating the lower of cost or charges (LCC) principle from the determination of rates of payment. Currently, Medicare limits reimbursement to home health agencies based on the lower of its costs or charges. This proposal will continue an exemption from the lower of cost or charges principle for certain public providers that offer services at a nominal charge.

[redacted]

Section 11276(d). Clarification of Part-time or Intermittent Nursing Care

Provisions: This amendment modifies two provisions of Medicare law that affect the eligibility of beneficiaries for home health services and the level of coverage available. With respect to the test to qualify for home health services, current law requires that the Medicare beneficiary demonstrate a need for skilled nursing care on an intermittent basis or a need for physical or speech therapy. At present, "intermittent" is not defined in existing statute or regulations. This proposal defines "intermittent" as skilled nursing care that is either provided or needed on fewer than seven days each week, or combined skilled nursing and home health services for less than eight hours each day, for periods of 21 days or less, with certain exceptions.

With respect to the level of coverage available for a qualified Medicare beneficiary, current law limits coverage of skilled nursing care and home care aide services to care that is "part-time or intermittent." There is no existing statutory or regulatory definition of this term. This section proposes to define "part-time or intermittent" services as a combination of skilled nursing and home care aide services furnished less than eight hours each day and provided for 35 or fewer hours per week.

[redacted]

"part-time or intermittent" is the result of a 1988 class action lawsuit that invalidated restrictions on daily, part-time care. The proposed definition of "part-time or intermittent services" eliminates an important protection currently available which allows for coverage beyond 35 hours per week under exceptional circumstances when the need for the additional care is finite and predictable. Currently, this component of the definition allows for short-term extended-hour coverage for individuals such as those awaiting placement in a SNF where no bed is available. It also makes care available to patients with a short-term, acute-care episode whose care could be provided at home, avoiding placement in a hospital or nursing facility.

The definition of "intermittent" proposed for use in qualifying a Medicare patient for home health services also adds new restrictions. Although existing law requires that the patient demonstrate a need for intermittent skilled nursing care, the proposal combines the need for skilled nursing and other home health services in determining whether the intermittent requirement has been met. This change would exclude from eligibility some patients who currently qualify for Medicare home health services coverage. For example, an individual who receives daily home care aide services from unpaid caregivers, such as family members, while receiving Medicare-covered weekly skilled nursing care would be entirely disqualified from Medicare coverage. Even if this definition were limited to the combination of skilled nursing and other home health services provided by a home health agency, currently eligible Medicare beneficiaries would be denied coverage.

To amend the Medicare statute in these ways would directly reduce home care to Medicare beneficiaries.

Section 11276(g). Definition of Homebound

Provision: This amendment establishes new criteria for determining whether an individual's absences from the home demonstrate that the Medicare beneficiary fails to meet the "confined-to-home" standard. Current law allows for nonmedical absences that are infrequent or of short duration. Medically related absences for treatment that cannot be furnished in the home do not affect an individual's homebound status. This proposal requires that an individual demonstrate the existence of a condition that restricts the ability to leave the home for more than an average of 10–16 hours per calendar month for purposes other than to receive medical treatment that cannot be provided in the home. The proposal further defines "infrequent" to mean an average of five or fewer absences per calendar month and "short duration" to mean absences of three or fewer hours on average per absence.

NAHC Analysis: This proposal would add to the confusion surrounding application of the homebound criteria. The proposal is subject to several possible interpretations. For example, although the existing law allows for absences which are either infrequent or of short duration, the proposal referencing absences averaging 10–16 hours per month may be interpreted to combine these two limitations. At the same time, the 10–16 hour reference may be interpreted in a manner that indicates that the restrictions for leaving the home begin only after that period since the word "restricts" is not the equivalent of "prevents."

Home care patients may have great difficulty in demonstrating that the treatment "cannot be furnished in the home." Currently, for example, most medically related treatments can be provided in the home. A visit by a physician can often adequately meet a patient's needs, but these services are not generally accessible in the home.

Many current Medicare beneficiaries, especially disabled patients, may be disqualified from Medicare home health coverage under this provision. In addition, rather than clarifying a confusing area, this proposal adds to the difficulty in interpretation and application by adding new terms that would also be subject to dispute.

Individuals that attend adult day care services through the use of specialized transportation and at no expense to the Medicare program should not be disqualified because absences are more frequent than five per calendar month or three hours per absence. These individuals generally cannot receive necessary health care services outside the home and are truly homebound without specialized transportation. Likewise, disabled individuals who are bedbound without the assistance of home health staff should not be disqualified where specialized equipment allows these individuals to leave their homes for education, employment, or other purposes. Disqualifying these individuals due to their absences eliminates the availability of essential services which create the opportunity for those absences. This provision would further disable, rather than enable, these individuals.

Section 11276(h). Normative Standards for Home Health Claims Denials

Provision: This provision authorizes the Secretary to deny the frequency and duration of home health services where that care is "in excess of such normative guidelines as the Secretary shall by regulation establish." This provision allows the Medicare program to utilize norms of care for eliminating coverage to individuals.

NAHC Analysis: The Medicare program's practice of using norms of care

was outlawed under a settlement agreement in the national class action *Duggan v. Bowen* in 1989. Under that settlement, the Medicare program is required to render *individualized* claim determinations that respect a particular Medicare beneficiary's illness, condition, and need for treatment. At that time, it was recognized by the Medicare program that the determination as to the level of care that was reasonable and necessary could only be rendered through an individualized review of that patient's circumstances.

This provision should be rejected. The federal government should not attempt to micromanage how much and what types of home care services each patient can receive. PPS for home care will provide prudent payments while letting health care providers determine how best and efficiently to meet patients' needs. A similar approach is used with Medicare hospital services under which a flat payment is made to a facility based upon a patient's diagnosis regardless of whether the patient receives care less than or in excess of the norms. The hospital payment provision provides for an outlier payment to recognize that certain patients reasonably require care beyond normative standards.

Further, the Secretary cannot reasonably and accurately establish normative guidelines for home care. Currently the Medicare program is developing a case mix adjuster for use in a future PPS. However, that case-mix adjuster, while categorizing patients, is expected to allow for flexibility in the provision of services to patients within the respective categories.

The use of norms implies an average amount of care for patients within set criteria. Averages cannot be used to deny coverage to individuals since the averages are made up of a range of care needs of specific patients. This proposal will guarantee that many individuals who need home health services would be denied Medicare coverage.

The implementation of this provision would also lead to an endless series of disputes, including litigation, regarding the accuracy and objectivity of the calculated norm of care for the particular category of patient. In the end, this provision will be costly to administer, creating harm to Medicare beneficiaries, leading to increased health care costs for underserved patients, and restricting coverage to individuals currently entitled under Medicare law.

Section 11292. Fees for Initial Survey and Certification

Provision: The Administration would allow states to impose user fees on providers for initial surveys needed for participation in the Medicare program. States would not be given authority to impose user fees for recertification surveys.

NAHC Analysis: NAHC opposes the user fee proposal and recommends that Congress ensure sufficient funds to cover the costs for survey and certification activities without imposing additional fees on providers.

For the past several years, HCFA's funding for survey and certification activities has been insufficient to complete the level of reviews mandated by Congress. As a result, many state survey agencies have been unable to conduct initial surveys of new providers in a timely manner. Providers in these states, therefore, are experiencing long delays in receiving Medicare certification.

The FY 96 budget (P.L. 104-134) contained a provision designed to provide HCFA the flexibility to begin to alleviate the backlog of initial certifications by increasing the time between home health recertifications for agencies meeting the conditions of participation from once every 12 months to once every 36 months and expanded HCFA's authority to deem agencies as certified if the agencies are accredited by certain private accrediting bodies. In addition, Congress appropriated an additional $10 million over FY 96 levels for survey and certification activities in FY 97.

Despite these legislative efforts, backlogs for initial surveys in some states still exist. The Administration's proposal would allow states to impose user fees on providers who wish to pay for their initial surveys. In addition, the President's budget reduces the direct appropriation to HCFA's survey and certification budget by $10 million. The Administration estimates that this $10 million reduction will be made up from user fees, thereby keeping the funding for survey and certification activities at FY 97 levels.

User fees are, in essence, a tax on new providers for participating in the Medicare program. Expecting high-quality care from providers who are required to shoulder both government costs and their own expenses related to the Medicare program is unfair. Moreover, while the proposal imposes user fees only on initial surveys, some existing providers may also be subject to this "tax." For example, home health agencies that wish to open a hospice would be subject to the fee for the hospice's initial survey. In addition, HCFA's recent reclassification of some home health branch offices as subunits would also require that initial surveys be conducted for those reclassified facilities.

Section 11293(a) and (b). Repeal of Certain Fraud and Abuse Provisions Implemented as the result of the Health Insurance Portability and Accountability Act of 1996

Provision: Subsection (a) calls for the repeal of advisory opinions; subsection (b) calls for the repeal of exceptions for risk-sharing arrangements to anti-

kickback penalties; subsection (c) calls for the repeal of the clarification concerning levels of knowledge required for imposition of civil monetary penalties.

NAHC Analysis: NAHC opposes repeal of the provider guidance provisions contained in the Health Insurance Portability and Accountability Act (HIPAA), P.L. 104-191.

The 104th Congress passed, as part HIPAA, a broad-based antifraud package that balanced increased enforcement tools with increased access to guidance for providers. The fraud and abuse provisions established a criminal health fraud statute and increased civil monetary penalties. At the same time, the legislation clarified existing law, created a safe harbor exception for certain risk-sharing arrangements, and allowed providers to request advisory opinions from the Department of Health and Human Services.

HIPAA's guidance provisions increased provider access to guidance and clarification of areas of law that have previously created confusion and led to unintended consequences for providers. Provisions such as the establishment of advisory opinions, expected to assist home health service providers in ensuring that they remain in compliance with health care statutes and regulations. Repeal of the advisory opinion provisions may result in the imposition of new criminal sanctions and increased civil monetary penalties on home health and hospice providers without adequate opportunities for guidance or clarification of existing law.

Section 11297. Development and Implementation of Integrated Payment System for Post Acute Services

Provision: This provision authorizes the Secretary to establish an integrated payment system for post-acute services furnished by SNFs, home health agencies, rehabilitation hospitals, long-term care hospitals, or such other entities as the Secretary deems appropriate. The payment system may include a single prospective rate for all services or a limit on the amounts payable to individual providers or to a single entity.

In establishing the payment system, the Secretary must consider equitable payments across provider types, case mix adjustments, geographic variation, and outlier payments. The Secretary must establish the system to be budget neutral. The system must include quality assurance and monitoring. Finally, the Secretary is authorized to require providers of services to supply the necessary data and other information needed for implementation, including the development of standard core patient assessment instrument.

The authority of the Secretary to implement an integrated payment system for post acute services does not apply to payments for services furnished before 2002.

NAHC Analysis: NAHC opposes combining or bundling home care payments with payments to other providers. Congress should, instead, enact separate PPSs for home care and other post-acute care providers.

Congress should also rebase the hospital DRGs to reflect shorter lengths of stay that have occurred under the hospital PPS.

Nearly half (41%) of all home care patients are now able to receive care and treatment at home from the onset of their illness, avoiding hospitalizations altogether. According to the Prospective Payment Assessment Commission's June 1996 report to Congress, patients in other post-acute settings were usually discharged from acute care hospitals, but only 59% of all home health episodes were preceded by a Medicare-covered hospital stay.

Bundling would vastly increase Medicare's administrative complexity and the cost of providing home care services by requiring multiple payment systems for home care—one for post-acute patients and one for other home care patients.

Mrs. JOHNSON. Thank you very much.

I would like to hear your comments about the issue of data. The administration says they cannot get a system in place to replace the cost of the reimbursement system that now exists until 1999, because they do not have the right information. I would like for you to talk to the Subcommittee about what information you think is available and why you think it allows us to move more rapidly than the administration proposes moving.

Ms. CUSHMAN. I think the first point is, phase 1 of the unified industry proposal for prospective payment is identical to the proposal put in place last year and endorsed by the administration and the Blue Dog Democratic Group in that, it would use existing data and provide the episodic limit on an annual cost basis, which information all currently exists.

We then move to phase 2, collecting data during phase 1, which we would like to see limited to no more than 24 months. During that period, a modified case mix adjuster could be put in place based upon the current demonstration project that the administration has in place and using that information, move to a full episodic system.

In addition to that, there have been many Subcommittee questions about quality and how some of that could be measured. I would point out that, again, we have a demonstration project in effect called the OASIS Model of Data Collection, also known as the OBQI study or outcome-based quality assurance. It is being done by the Denver Health Policy Center. Our 50 agencies are currently testing this. It is a benchmarking, outcomes system which we have heard the Health Care Financing Administration indicate they plan to make a basic condition of participation for all home care agencies.

Mrs. JOHNSON. Could you describe OASIS a little bit more extensively in terms of how it monitors quality?

Ms. CUSHMAN. Really quickly, there was a large assessment tool done on the intake of a new client to the home care agency, gathering basic demographic information, expectations from proven, specific information about what the patient needs. Then using that information, it measures it at future intervals. It also includes some patient satisfaction information in the correction.

The agency then submits its data to the Denver Health Policy Center. All of that is computed against all other agencies in the country. Then you receive a report in terms of how your agency is doing on each parameter for each grouping of patients against the Nation with requirements to improve against those benchmarked areas.

Mrs. JOHNSON. As opposed to the current system, it provides a far more indepth analysis of the patient's condition and then looks more precisely at progress made relative to services provided?

Ms. CUSHMAN. That is correct, results of care.

Mr. KOPPEL. We will be able to look back from this data in 2 years and get a pretty good grasp of the impact on the beneficiary of x number of visits or x plus five or whatever?

Ms. CUSHMAN. All of that data is currently being collected. What this will do is provide the means to connect the number of visits made with the actual results of care rendered. I would caution that the demonstration agencies, of which there are 15 in the country—our agency happens to be one—which is how I can speak to this.

We have just received our first benchmarking report against other agencies, but by the time we would be moving to a second and third part of this system, all of that information from the demonstration would be fully available.

Mrs. JOHNSON. That is really important information. Would you like to comment, Mr. Hafkenschiel?

Mr. HAFKENSCHIEL. Yes.

There are two big data bases that currently exist in Medicare home health. The first is the claims data base and the second is the cost report data base. They provide the vast majority of the data we would need to implement this system. There are some problems with the accuracy of some of those data, but with all data systems, if you are not using the data for something, it is liable not to be very accurate.

I can guarantee the Subcommittee that, if this system is implemented, data will get accurate very quickly.

Mrs. JOHNSON. In other words, you are saying data is available to move ahead promptly even though we may want to refine the system in years thereafter as we did with DRGs and other changes in reimbursement that we have adopted?

Mr. HAFKENSCHIEL. Yes, every home health agency in the country submits an annual cost report and they submit a claim for every service they render. It is a huge amount of data.

Mrs. JOHNSON. I thank you.

Mr. Cardin.

Mr. CARDIN. Thank you, Madam Chairman, and let me thank the panel for their testimony.

I want to follow up a little bit on the home health care services and moving to the PPS system. If I understand the differences between what we know about the administration's proposal and what the industry is recommending, it is first that you would recommend we start to move into a PPS system within 6 months after the enactment. The administration believes it should be October 1, 1999?

Mr. HAFKENSCHIEL. Yes.

Mr. CARDIN. We have a timing difference.

Second, you are suggesting that we start with a per-visit limit; is that correct?

Mr. HAFKENSCHIEL. With an aggregate limit on top of the per-visit limit, limiting the total payments to the agency.

Mr. CARDIN. Immediately, within the 6-month period?

Mr. HAFKENSCHIEL. Yes.

Mr. CARDIN. You would implement the per-episode amount as well as the per-visit amount?

Mr. HAFKENSCHIEL. It is really a per-patient amount in the first phase.

Ms. CUSHMAN. Yes, the first phase episode limit which is similar to what was proposed by the administration last year, incidentally, is using the cost report data that Mr. Hafkenschiel talked about, the annual cost per episode. So, it is using a 1-year timeframe,

which data is available currently from the Medicare cost reports on cost per beneficiary per year.

That is not an accurate future episode basis to call 1 year an episode. Basically what would happen, beginning in order to have an episode limit.

In future periods—I am talking about phase 2—we would limit an episode to 120 days, and step in a beginning case mix modifier.

Mr. CARDIN. I understand. Your written testimony indicates the plan contains a savings sharing provision which will provide incentives to further reduce the number of visits per patient.

Can you elaborate on that.

Mr. HAFKENSCHIEL. The way the proposal works is that if your total per-visit payments are less than the aggregate limit, you get to retain a share of those savings equal to 50 percent of the savings, but limited by a 10-percent cap. Then there is one other feature to it. But essentially, if you came under the limit by $100,000, you would retain $50,000, and of course HCFA, or the Federal Government, would save $50,000.

Mr. CARDIN. Your savings would be on the number of visits? Is that how the savings would be achieved?

Mr. HAFKENSCHIEL. Your savings would be by holding the total number of visits at the rates per visit under the total payment cap. Yes.

Mr. CARDIN. Is it the number of visits, or are you going back to cost basis?

Mr. HAFKENSCHIEL. It is the product of the number of visits you make times the cost per visit. That is how the limit is calculated.

Mr. CARDIN. The cost per visit is what is established under the PPS system; not your costs?

Mr. HAFKENSCHIEL. It is provided by base 1994 costs and 1995 visits. So it is taking historical data and constructing a limit out of that, and then trending it forward to reflect the date when the system goes into effect.

Ms. CUSHMAN. Could I add to that? And yes, it would have a 75-percent agency-specific data, and a 25-percent census reaching data, and achieving that blend of what the cost was.

Mr. CARDIN. You said the 50-percent savings would be retained by the provider with a 10-percent cap. I did not understand the 10-percent cap.

Mr. HAFKENSCHIEL. The savings retained by the provider could not exceed 10 percent of their annual payments, and the reason why that limitation is put in there is so utilization would not be driven too strongly downward by the incentives in the system.

Mr. CARDIN. The maximum basically is 110 percent of their payments. That is 10 percent more than what they would otherwise receive?

Mr. HAFKENSCHIEL. Correct.

Mr. CARDIN. The maximum they could receive under the incentive program.

Mr. HAFKENSCHIEL. Correct.

Mr. CARDIN. Thank you, Madam Chairman.

Mrs. JOHNSON. Just to follow up, to clarify one aspect of your discussion, that the total cost limit per agency would be based on 75 percent—75 percent of that based on the agency's cost, but 25 per-

cent would reflect the average of the region, so that a high-cost agency would not be unaffected by the average in the region. And then later on in the proposal, that goes to 50 percent; 50 percent, your cost, and 50 percent the regional cost average——

Mr. CARDIN. When does that happen? Is that spelled out in the——

Mrs. JOHNSON. I have forgotten how many years.

Mr. HAFKENSCHIEL. I believe it is within 1 year of—it is in the second year of the system, it goes to a 50:50 ratio.

Mrs. JOHNSON. That is correct.

Mr. CARDIN. And what you have indicated, is that information currently available?

Ms. CUSHMAN. Yes, it is. In fact we also are recommending—and I think given the earlier questions this may be significant—that the utilization data be based upon 1995, and that the cost data be based upon 1994, updated with marketbaskets, in order to avoid some of the inflationary issues that people are concerned about between proposing prospective payment and implementing.

Mrs. JOHNSON. But this blending of regional rates will have the effect of reducing the enormous gap between payments for similar services.

Mr. McCrery.

Mr. MCCRERY. Thank you, Madam Chairman.

I do not have any questions, right now. I just want to say I do appreciate the industry coming up with such a detailed proposal. I am in the process of digesting all of it, and from what I have seen so far, it is a step in the right direction and something we ought to take a careful look at.

Thank you.

Mrs. JOHNSON. Mr. Christensen.

Mr. CHRISTENSEN. Mr. Chies, right?

Mr. CHIES. C-h-i-e-s.

Mr. CHRISTENSEN. Mr. Chies, in your testimony, you talk about the SNF growth dropping to 10.6 percent next year, and in the single digits in 1999. This trend line drops to under 7 percent in 2002 without any intervening congressional action.

Do you have some reasoning for that, and some basis?

Mr. CHIES. That comes out of the Congressional Budget Office numbers, and we have a chart that we can provide you that will be handed out to show those numbers.

Mr. CHRISTENSEN. During your testimony, you said that you had some other basis, though, that you wanted to talk about, if you had more time.

Do you have any other documentation with you at this time?

Mr. CHIES. In terms of the cost growth, why it has gone where it has gone, or why it has leveled off at this point?

Mr. CHRISTENSEN. Why it is projected to go down to 7 percent in year 2002.

Mr. CHIES. It is probably grown as far as it is going to grow under the current benefit. If you take a look, historically, of why it has grown to this point in time here, we have the passage of the 1988 catastrophic act, then the subsequent repeal of the catastrophic act, and on top of that a court decision which basically redefined what the SNF benefit is.

On top of that, we had a change in the marketplace over the last 20 years. Hospitals have been trying to operate in a much more efficient way to discharge residents, to capture a greater part of their DRG payment. So nursing facilities have subsequently had to pick up the slack on those residents.

The earlier panel mentioned the ancillary increases. A couple of reasons for that. One is the quicker discharge from the hospital. We are seeing individuals, that 10 years ago, would have been in the med surg wards of hospitals. They are now in nursing homes today, hanging IVs, Hickman catheters, a series of very complex, critical pieces of medical equipment that we are doing.

On top of that, the 1987 OBRA law, which has a provision in it that requires people to move to the highest practical level of functioning, requires an additional scrutiny, an additional need for the ancillary services. And the ancillary services we are talking about are physical therapy, occupational therapy, and speech therapy. And those are probably the biggest combination of why things have increased. On top of that, and I can tell you anecdotally, at one of my facilities in the last 10 years, we went from a 1-percent Medicare utilization to almost an 8-percent Medicare utilization.

Most of that growth is due to the hospital DRGs and the increasing physical needs of the residents. But a substantial amount of that growth has been caused by the State of Minnesota mandating that facilities become dually licensed or dually certified, both in Medicare and Medicaid, and a pretty aggressive recovery program by the State agency, the State Medicaid agency, to make sure the Medicare benefit is full and it is extracted to the last penny.

Mr. CHRISTENSEN. I think in 1990, the average SNF average payment per diem was about $100. Over the last 7 years, it has gone up to about $265 per day.

I know you are getting sicker patients from the hospitals. That is a large part of the reason the cost has gone up. What are some of the other reasons that costs have gone up on the average per diem?

Mr. CHIES. Most of it is in the ancillary service area. It is the additional therapy services that are being required to get those people up to their highest practical level of function.

Mr. CHRISTENSEN. Is that it?

Mr. CHIES. Pretty much.

Mr. CHRISTENSEN. OK. That is all, Madam Chair.

Mrs. JOHNSON. I would like the panel to return to a subject that you are in disagreement with, in terms of the testimony of the preceding panel. Now, only one member of the preceding panel commented on this, but he seemed to feel that there would be no additional costs associated with moving one-half of the home health care reimbursements to part B.

And you have mentioned, some of you have mentioned that you think this dual payment issue will increase costs.

His comment was that the payment would all be made by the fiscal intermediary, so you would be dealing with, in a sense, a single payor, even though out of two different pots of money.

Would you like to comment further on why you think this would increase provider cost?

Mr. HAFKENSCHIEL. My understanding is the two parts of the program use different claims forms, and even though it goes to the same fiscal intermediary rather than the part B carrier, you are using two systems of billing.

There is also a different appeals system in part A and part B. And then probably the biggest piece is the tracking issue. You are going to have to identify on the front end—and this is not too hard—where the patient is coming from.

But then you are going to have to monitor their 100 visits, and when they get to 100, switch them over to part B.

It just seems that at this stage of restructuring the system, we should not increase the complexity level of the system.

We should solve the real problems and get on with it.

Ms. CUSHMAN. In addition to that, it occurs to me that we would have problems as it relates to the periods of start of care. Would the same certification do, since 100 visits would not necessarily correspond with the certification period?

And as I was listening to the questions being raised, I thought of a new one which deeply concerns me in New England, and that is how would part A and part B Medicare interface with the entire issue of third-party liability, that the States' Medicaid systems are going to agencies to try to find, and how would we ever begin to track who paid for which visits, and how to keep all of that information straight?

Mrs. JOHNSON. Thank you. That is very helpful. I think sometimes those who deal primarily with the Federal Government and fiscal intermediaries forget a little bit about how those out in the real world have to respond to those entities.

Then would you just comment further, Ms. Cushman, on your brief comment about CBO and its unreasonable adjustment, and what that would do to the whole system, and a little bit more on the differences between your estimates and CBOs.

Ms. CUSHMAN. CBO has estimated that there is a 66⅔-percent gaming factor on the home care, prospective payment system as proposed, unified by the industry.

Our understanding of the savings, depending upon which piece of it is tweaked——

Mrs. JOHNSON. Excuse me. What do they mean by gaming?

Ms. CUSHMAN. Gaming. What was shared with us is the notion of gaming is how they will discount by the scores by what they can presume will not take place when the system is actually in place, especially that which providers might do to adjust their behaviors against——

Mrs. JOHNSON. Is this what we used to call volume changes?

Ms. CUSHMAN. That is one possibility. Another that was shared in an original letter, that CBO explained, is they use a factor to account for if they do not believe the administration would implement a system, or would implement it later. Then it discounts the scoring as well.

Mrs. JOHNSON. OK. Thanks.

Further comment? I interrupted you.

Ms. CUSHMAN. One of the very important differences that we have with CBO, that was not even taken into account in their discount, is the savings sharing that was discussed a moment ago by

Mr. Hafkenschiel against the new aggregated caps, and that was not considered as a potential scoring factor.

So we have had an independent Big Six firm review this proposal and come up with ranges of savings that equal either what the administration was looking for last year, or the Balanced Budget Act of the House of Representatives.

Mrs. JOHNSON. Are there other comments on that?

Are there other questions by the Subcommittee?

Thank you very much. We appreciate your being with us.

The Subcommittee stands adjourned.

[Whereupon, at 3:28 p.m., the hearing was adjourned, subject to the call of the Chair.]

[Submissions for the record follow:]

Statement of Sheldon L. Goldberg, President, American Association of Homes and Services for the Aging

INTRODUCTION

Mr. Chairman and Members of the Committee, I am Sheldon L. Goldberg, President of the American Association of Homes and Services for the Aging (AAHSA). I am grateful for the opportunity to submit testimony for the record of your hearing on the President's FY '98 budget proposals regarding Medicare payments for Skilled Nursing Facilities and Home Health Agencies.

AAHSA represents not-for-profit organizations dedicated to providing high-quality health care, housing and services to the nation's elderly. Our membership consists of over 5,000 not-for-profit nursing homes, continuing care retirement communities, senior housing facilities, assisted living and community-based service organizations. With our broad range of facilities and services, AAHSA serves more than one million older persons daily. We have a long history and consequently, significant experience in meeting the needs of the elderly. We recognize the important role that the Medicare program has played in ensuring that the health care needs of older Americans are adequately met.

The future of the Medicare program will be affected by a rapidly growing population of the elderly and individuals with disabilities, diminishing resources in the Hospital Insurance Trust Fund, and growing costs of providing medical care. This future presents many difficult problems that this Congress and the next must face, if the country is going to maintain its commitment to its seniors. We appreciate the competing and sometimes incompatible demands that you must reconcile in order to keep the Medicare program operating. We pledge to work with you in any way possible to control health care spending and reduce the national deficit while still preserving access to high quality skilled nursing, home health and other health care services for our nation's elderly.

Our members include not-for-profit home health agencies (HHAs) as well as skilled nursing facilities (SNFs) and my comments today generally apply to both types of providers, since many of the issues relating to prospective payment are similar. We will specify when referring to one type of service in particular.

LONG-RANGE VISION

Looking well into the future, we believe our members will be actively participating in managed care. They will be providing care and services financed by systems that coordinate care across time, place and provider. These systems will emphasize prevention, risk-sharing and appropriate utilization of services based on consumer and community demand for maximum health and well-being at lower overall cost.

We see the beginnings of these systems now, as evidenced by the growth of managed care and Medicare beneficiaries' growing participation in Health Maintenance Organizations (HMOs). There is a greater use of cost-effective, post-acute services and fewer days spent in expensive, acute care hospitals by managed care enrollees. Managed care organizations already receive substantial cost savings from the use of subacute care services without a three day prior hospital stay and from the substitution of post-acute care for unnecessary hospital days. Unfortunately, the Medicare program currently can not reap the same savings from these trends.

In particular, Provider Sponsored Organizations, (PSOs) represent an opportunity for our members to demonstrate their expertise in managing the chronically ill population. The development of Provider Sponsored Organizations that permit affiliated

providers to join in a risk sharing network should provide as many opportunities as possible for diverse participation by long term care providers. Qualified PSOs must offer the full range of Medicare primary, acute and skilled nursing services, and may offer additional benefits, including vision, hearing, and pharmacy services.

Medicare Budget Proposals

AAHSA recognizes the need to reform the Medicare program in order to prolong and preserve the solvency of the Part A Hospital Insurance Trust Fund. It is necessary for all involved with the program to contribute to that end, including beneficiaries and the government. We are concerned, however, with the disproportionate burden being shifted to the providers of care and services.

We understand that health care providers cannot continue with a "business as usual" attitude. It is also important for Congress and the Administration to understand that, with current major cutbacks in state Medicaid programs and the growth of managed care, SNFs and HHAs will not have the flexibility to cross-subsidize unreimbursed costs for Medicare patients with revenue from private patients.

Expecting skilled nursing facilities to absorb $9 billion in budget cuts over the next 6 years and home health agencies, $18 billion, through the implementation of the Administration's budget proposals is just not realistic. Therefore, AAHSA proposes the following cost saving measures to help reduce the need for such drastic cuts:

- First, the elimination of the three day prior hospitalization requirement for selected diagnoses would permit the substitution of less expensive subacute care in SNFs and HHAs for the more costly acute hospital care.
- Second, the revision of acute hospital prospective payment rates, based on current lengths of stay, would permit Medicare to accrue savings from the substitution mentioned above and from the growing use of cost-effective subacute services instead of more expensive acute care days at the end of hospital stays.

Prospective Payment Systems for SNFs and HHAs

We recognize that reform of the current retrospective, cost-based reimbursement system is inevitable and that some form of prospective payment is likely. The current Medicare PPS for low-volume SNFs is a start that has been working fairly smoothly, but it is only a first step. A well designed PPS could promote management efficiencies and create some savings for the Medicare program. But a poorly designed PPS could mean unintended consequences that might harm the Medicare program, its beneficiaries, and the long-term care industry.

We have seen from the implementation of the hospital PPS that the health care industry is very complex and can react in unexpected ways to PPS incentives. For example, the reduced hospital length of stay was an anticipated and desired result of PPS implementation. With hindsight, the growth of subacute care based in hospitals seems a natural result, but it was not as clearly expected at the time of implementation. Prior experience would argue for implementation of a PPS very gradually and with careful evaluation of its implementation and impacts.

GOALS: While the most immediate objective for initiating a prospective payment system (PPS) may be to produce program savings, it certainly is not the only one. Following are some other goals that ought to be included when designing a new reimbursement system.

- Access to care: The PPS should facilitate the timely movement of Medicare patients from acute care to the appropriate post-acute care setting. Reimbursements should not be set so low that providers would be reluctant to accept patients with high acuity, needing relatively intense or lengthy courses of treatment.
- High quality care: The PPS should reward high quality care and focus on quality outcomes.
- Efficient use of resources: The PPS should encourage efficiencies while recognizing that circumstances will vary from one provider to another. The choice of service setting or provider type as well as the specific mix of services to be offered should be encouraged to reflect the efficient use of resources as well as medical necessity and patient choice.
- Ease of administration: The current system of cost reporting with retroactive adjustments, audits, and settlement delays is cumbersome and costly. Management of the program by Medicare and of the service by the provider should be greatly streamlined.
- Innovation: Given the current dynamism of the health care market, the PPS should not lock-in the status quo, rather it should permit and encourage innovation and change. It should also recognize the costs of compliance with any new federal requirements, such as changes in the minimum wage or OSHA.

Underlying Assumptions: Basic to the achievement of these goals are some important underlying assumptions.

- Skilled nursing facilities must rehabilitate Medicare beneficiaries in their care to the highest practicable physical, mental, and psycho-social well-being. This is federally mandated by OBRA '87.
- In general, Medicare payment for nursing care and home health services should approximate the reasonable costs of efficient providers. It does not matter how finely constructed are the incentives of the PPS, if there is not a realistic level of funding in the system.
- There are some legitimate geographic and regional differences, such as labor market wages, and factors affecting provider costs that are to be expected.
- Not all costs of producing services can be controlled directly by management.
- The growing expenditures of the Medicare program, and post-acute services, particularly, result not only from the lack of a PPS. Growing expenditures result also from growing numbers of beneficiaries with greater needs for services, increasing medical needs of patients resulting from shorter lengths of stay in acute care hospitals, and improved treatments, new technologies, drugs and supplies.

Elements of the Prospective Payment Systems:

Case Mix Adjustment: Basic to the achievement of almost any of the goals mentioned above is the ability of the PPS to discriminate among patients requiring different levels and types of care and associating that with the resources used in treatment. In other words, residents or clients requiring more expensive and extensive courses of treatment should generate a payment amount greater than the average patient. Likewise, a relatively easy care patient should generate a payment less than the average. However, there should also be an incentive to rehabilitate the patient and move a high acuity patient to a higher functional level with a less intense level of service needed.

In the acute care hospital, prospective payment per case is set by diagnosis, but a classification by diagnosis for post-acute care is not a good predictor of resource use. Functional limitations are a better indicator of costs of care within a given post-acute care setting (SNF or HHA). Nonetheless, further refinements are needed to develop acuity adjusters that reflect the resources used in a day of SNF care or in treatment of an episode of care.

AAHSA is very concerned with the administrative mechanisms for linking the case mix of a SNF patient with the appropriate payment level. The MDS resident assessment is not completed instantly upon admission and, indeed, is not required for completion until the 14th day. Many subacute patients leave before it can be completed. If the prospective payment is dependent upon MDS data for determining the patient's acuity level, how will providers be paid for such cases as well as for the early days of any stay without adding enormous administrative burdens on the facility to speed up the MDS process? How quickly will HCFA develop an abbreviated MDS suitable for short-stay patients? Could initial acuity levels for payment purposes be determined from hospital discharge data or some other source?

A case mix adjuster for HHA patients is also far from full development, although the second phase of a demonstration project is in operation. There is not yet any case mix adjuster that explains a significant amount of the variation in costs per case or episode for post-acute care. It is essential that case mix adjusters for both HHAs and SNFs be developed, refined and tested as quickly as possible before a PPS is put into effect.

Unit of Payment: The most commonly mentioned units of payment are: episode/case/stay and per diem/visit. While it is relatively straightforward to define a visit or day for payment purposes, defining a post-acute case or episode of care or a SNF stay becomes more complex. Care of a Medicare beneficiary in a post-acute setting can be punctuated by an acute incident requiring temporary hospitalization and then a return to the same or a different SNF or HHA. Or, a resident may leave the SNF to return home, have a relapse or find it impossible to manage at home and then return to the SNF. Likewise, a HHA client might stop service for a period, either because of an acute or post-acute care admission or for lack of continuing need, but then return later to HHA care for the same diagnosis.

Defining and keeping track of a beneficiary's treatments during an episode of post-acute care requires very sophisticated and integrated information systems. Even with a clear definition of episode, it will be difficult determining norms for payment purposes. The appropriate, medically necessary post-acute care course of treatment can vary significantly, even for patients with the same diagnosis or functional level. In addition, the social and family supports and personal preferences of a beneficiary can affect the length of treatment and setting.

The choice of payment unit affects the incentives of the PPS. These incentives would need to be carefully balanced with an effective quality assurance/outcomes monitoring system. With a payment per episode there would be an incentive to reduce/eliminate unnecessary services. Similarly, it could provide an incentive for underservice or early discharge.

For home health, in which Medicare's concern is with an increasing proportion of cases receiving long courses of treatment with many visits, a payment per episode would be appropriate. However, such a mechanism to control volume of services in the home health setting would need to be balanced by effective monitoring of quality and outcomes as indicated in the OASIS demonstration and a payment process for exceptional cases.

The choice of a unit of payment for SNFs is different and should be a per diem, as the administration has proposed. Acute hospitals have had a PPS based on episode for a dozen years. After observing the trend of those hospitals to discharge patients "quicker and sicker," we fear the risks of that method for SNFs. The incentive to discharge SNF patients more quickly could have a detrimental effect on beneficiaries as well as on Medicare payments to other acute-and post-acute care providers. There is no evidence of an increase in the average length of stay of Medicare skilled nursing patients or of dramatic increases in the proportion of beneficiaries using SNFs that would justify such an incentive. Medicare's concern with the growth in the number of therapies/ancillary services could be met with a per diem payment. In addition, the SNF Medicare benefit has a limit of 100 days and a copay of $95 per day after the 20th day (unlike the unlimited HHA benefit) which probably helps deter unnecessary utilization.

Covered Costs: Ultimately, the PPS should include all costs related to caring for Medicare beneficiaries: routine, capital and ancillary costs for a SNF and visit, travel, and administrative costs, etc. for a HHA. A comprehensive payment is more attractive administratively for the program and the provider, facilitates planning and permits flexibility of operations. However, an all-inclusive payment presumes a knowledge of all the components of care and associated costs that currently go into an episode or day of care and a norm of what volume of service ought to be included. That information and understanding is not yet available. Thus, a phased-in approach, perhaps covering only routine costs initially with other costs (capital and ancillaries passed through), until complete data are available would make more sense at the start of a PPS.

HCFA has a Multistate Skilled Nursing Facility Medicare Case-Mix Demonstration currently underway. Soon, HCFA should be receiving data from it on case mix adjusted payments for SNF care that includes some ancillary costs along with routine costs. However, the project is very limited in the number and geographic spread of participating facilities as well as limited in the costs covered. Related to this Case Mix Demonstration is a Staff Time Measurement Study designed to gather more data on resource use linked to patient acuity, with special emphasis on subacute care. Even with this extra study, that data are very limited for creating a nationwide case mix system including all SNF costs. The evaluation of the demonstration will not be available in the near future

Even with the case mix demonstrations, HCFA will not have complete data on all the ancillary services and supplies and their costs that are currently associated with particular categories of cases. Treatment protocols and clinical pathways for common post-acute diagnoses are still under development. It will be difficult devising reasonable assumptions about numbers of HH visits and appropriate SNF ancillary costs to cover in an all-inclusive payment. This again would argue for a phased-in approach.

Consolidated Billing: AAHSA understands that HCFA will be requiring all bills for services and supplies delivered to SNF Part A patients to be processed through the SNF. We understand the need to include all bills to keep the PPS payment comprehensive and all-inclusive. We also understand the possible benefits in terms of reduced waste and fraud by suppliers. However, we are extremely concerned about the administrative burdens placed on the facility and the need for HCFA to develop a workable system in conjunction with the industry.

Inflation Factor: Any PPS must recognize the impact of inflation on the provision of services. The "market basket" approach used for the Medicare low-volume SNF/PPS makes sense. However, the projections and updates should be made in a timely fashion to assure their accuracy and close proximity to reality, since a retroactive adjustment for inaccurate projections would be counter to the prospective philosophy. In addition, the cost basis for calculating the PPS rates must be rebased periodically in order for it to reflect current medical practices and costs.

Since the design of the PPS is predicated on the assumption of realistic levels of payments, it would be a gross distortion of the system to use the inflation factor

as a mechanism for reducing the payment levels to meet arbitrary congressional or administration budget constraints. The ease of abusing the inflation factor, for example, by setting it at market basket minus 2%, shows a clear disregard for the goals of PPS and makes the industry leery of supporting any reimbursement change.

Other Adjustments: Geographic adjustments are important for recognizing variations in costs affected by place of service (urban/rural) and costs of labor in different markets. Such adjustments are included in the low-volume Medicare SNF/PPS and the hospital PPS system and appropriate mechanisms should be included in any new PPS system for both SNFs and HHAs.

Outliers: Even with a sophisticated, fully tested case mix system, there will be a need for recognizing exceptional cases requiring substantially more services than the norm. With a crude case mix system still under development and not fully tested, the exceptions process becomes even more important. This is particularly true with respect to home health, where the benefit is not time- or visit-limited.

Implementation Schedule: The administration's proposal to begin PPS for SNFs as early as July '98 and 1999 for HHAs seems overly optimistic given the inadequacies of the essential data bases and methodologies. AAHSA recommends another year to develop each system and then a slow phase-in. Each PPS should be phased-in gradually over at least six years to permit smooth implementation and the avoidance of drastic and inappropriate changes. The PPS could cover gradually increasing categories of costs and/or could be a blended rate based on a provider's current payment and the new PPS rate.

Site Differentials: In keeping with the goal of matching the payment amount to the acuity of the case and level of services needed, AAHSA recognizes the need to eliminate the differential payment for hospital-based SNFs and HHAs. It is important to create a level playing field for free-standing and hospital based providers.

Waiver of Liability: This item is missing from the administration's budget proposal, but should be added. Given the complexity of Medicare's eligibility rules and definitions, providers of SNF and HHA services need the reinstatement of the waiver of liability, whether the payment system is retroactive or prospective. This is necessary to protect innocent, careful providers who unintentionally and on rare occasion, make a coverage mistake and to ensure the timely availability of services to beneficiaries.

Other Budget Proposals

Post-Acute Care Payment System: The Prospective Payment Assessment Commission (ProPAC) has recommended the bundling of acute and post-acute services into a single payment for the episode of care. Superficially, the proposal to bundle payment for all post-acute services with the prospective payment to the acute care hospital may seem to promote the efficient substitution of care in cost effective settings and program savings. However, in reality, it would create distortions in the marketplace and would shift control of patients back to the hospital. Much of post-acute care, particularly for the chronically ill, would suffer from the over-medicalization of the treatment model. Also, hospitals would have an incentive to retain relatively lower cost patients in their own nursing units and to discharge relatively higher cost patients to free-standing facilities, but their incentives concerning payments would be to retain more money to cover their own higher cost nursing units and to contract with free-standing facilities at reduced rates. The trend towards integrated delivery systems, combining primary, acute, post-acute and long-term care providers with case management and equitable sharing of risk, has a greater potential to improve the quality of care delivered to beneficiaries and to produce savings. This is mainly because there would be less bias towards the most expensive providers.

The administration's budget proposal does not go as far as ProPAC's; it focuses on bundling only post-acute services. As is clear from the earlier discussion of PPSs for home health and skilled nursing facilities, there is a long way to go in perfecting case mix and other adjustments for those systems. The development of a totally "site-neutral," case-mix adjusted, episodic payment system predicated upon a standard core patient assessment instrument belongs in the 21st century or beyond. One can not debate the merits of such a concept now, without any details. The health care world will look substantially different by the time HCFA has the capability of designing any such system and the concept may no longer be relevant. Certainly it is premature to grant the Secretary blanket authority now to develop and implement such a payment system through regulation at some future date. Whenever the Secretary has details of a realistic system to propose, it should be done through the legislative process with congressional oversight and adequate public participation. In the meanwhile, AAHSA supports authority only for the Secretary to collect data

necessary for analyses of related issues. We do offer the caveat, however, that SNFs are still in the process of computerizing the MDS and that any additional reporting burdens on providers be weighed very carefully before any new data collection efforts are started

Centers of Excellence: AAHSA is opposed to the expansion of this program to include such procedures as hip and knee replacement and to include post-acute services in the single rate because the acute care hospital often does not have the necessary gerontological skills to manage Medicare patients needing extensive post-acute care, rehabilitation and support services beyond the medical model. The previous discussion of the current impossibility of case mix adjustments to account for the related costs of an episode of care in just one setting (a SNF or HHA) make this proposal seem even more farfetched. Given those inadequacies, it is not realistic to expand this purchasing program. Certainly such a program should undergo careful scrutiny and evaluation before substantial expansion.

Purchasing Through Global Payments: AAHSA is interested in knowing the details of this proposed program. AAHSA members are uniquely prepared to focus on the continuum of needs of the chronically ill and they recognize the cost-effectiveness of high quality preventive care and supportive services in maintaining the elderly in the least restrictive setting. Ideally, however, such integrated care should be comprehensive and focussed on the whole individual, not just on a particular diagnosis, since the elderly frequently have co-morbidities and functional limitations. A truly effective chronic care program would not necessarily produce cost savings within 30 days and we question the value of such an approach with only a 30-day lock-in.

Definition of Transfer and Discharge: AAHSA is opposed to the redefinition of transfer and discharge from an acute hospital to any post-acute care setting. Such a change would make it advantageous for acute hospitals to hold on to their patients longer than is necessary. Again, Medicare needs to revise the length of stay assumptions on which DRG payments are based, in order to benefit from the true savings of the post-acute care providers, who treat subacute patients at a lower cost than do acute care hospitals.

User Fees: AAHSA is opposed to Medicare's imposition of user fees charged to providers of Medicare services and services for the dually eligible for initial certification. However, AAHSA recognizes that HCFA's resources for survey and certification are insufficient to accomplish its current responsibilities without changes to the process. AAHSA supports legislation to allow for deeming of nursing facilities through a national private-sector agency as an option under Medicaid as well as Medicare.

PACE and SHMOs: AAHSA supports the shift of demonstration sites in the Program of All-inclusive Care for the Elderly (PACE) into full provider status because the model has proven to be a cost-effective way to provide integrated care to the frail elderly. In addition, new providers that meet the PACE standards should be given permanent provider status. The extension of the Social Health Maintenance Organizations demonstrations is warranted to allow a full evaluation of this service delivery model.

Home Health Shift from Part A to B: AAHSA supports the transfer of some home health care coverage from Part A to Part B, recognizing that, in itself, this will not reduce total HHA expenditures. However, such an interfund transfer can make a significant contribution to prolonging the solvency of the Part A Trust Fund. AAHSA emphasizes the importance of the Administration's accompanying language which will ensure that the beneficiary bears no additional costs resulting from this transfer of HHA benefits.

Payment for Home Health Services Based on Location Where Service is Provided: AAHSA supports the administration's proposal that home health payment be determined from the site where the service is actually furnished the patient's home rather than the HHA's home office and wants that proposal to be very clear.

Respite Benefit: AAHSA applauds the administration's recognition of the crucial role played by the family and other caregivers in supporting the elderly with chronic health problems and disabilities. We realize that budget constraints dictate a very small benefit. Respite care for beneficiaries suffering from dementias is a reasonable place to start. However, the greatest need for relief often hits those caring for beneficiaries who are totally homebound, totally dependent and needing a round-the-clock presence of a caregiver. To provide real relief to the caregivers, a brief escape from their heavy burdens, and to permit them to carry on for longer periods on their own, it may be necessary to offer a brief and temporary stay in a SNF. Including SNFs as respite providers could prove cost-effective in the long run by delaying or preventing eventual admission of the dementia patient to a SNF for long-term care.

CONCLUSION

We recognize the need to move forward with new and improved payment systems to cover Medicare SNF and HHA patients. Well designed and implemented Prospective Payment Systems for all SNFs and HHAs could meet many of the needs of the program as well as of providers and beneficiaries. We are concerned, however, about imposing too rapidly any system that has been inadequately tested and is based on insufficient data. In addition, the level of payment reductions, ($9 billion from SNFs and $18 billion from HHAs over 6 years), are excessive, unnecessarily high and threaten the provider's ability to deliver high quality care.

In conclusion, we recommend:

- The three-day prior hospitalization requirement be eliminated for selected diagnoses;
- The PPS payments to acute care hospitals be revised to reflect more accurately current lengths of stay;
- The Waiver of Liability be reinstated;
- The collection of necessary cost and utilization data and the evaluations of the case mix demonstrations as quickly as possible;
- The refinement of quality assurance systems based on outcomes monitoring to protect against negative impacts on patients of payment system changes and reductions;
- The gradual implementation of PPSs only after the development of complete data sets that are needed, fair and equitable methodologies are tested, and reasonable payment levels are set;
- Monitoring of program implementation to spot potential problems early. Monitoring should include evaluation of the implementation phases and their impact on the health care industry broadly and on SNF and HHA providers, beneficiaries and their quality of care and the quality of life, in addition to their impact on Medicare's budget. Changes and revision of the PPSs should be expected based on the evaluation.

We look forward to working with you in the months ahead to help develop a payment system that will work for Medicare, its beneficiaries, and the whole post-acute care industry. Thank you for this opportunity to present the views of the not-for-profit nursing facilities and home health agencies who are members of the American Association of Homes and Services for the Aging.

Statement of American Federation of Home Health Agencies, Ann B. Howard, Executive Director, Silver Spring, Maryland

The American Federation of Home Health Agencies (AFHHA) is a national association representing primarily free-standing Medicare certified home health agencies. AFHHA urges Congress to enact wise reform of the home health reimbursement system while ensuring access to care for beneficiaries with continuing skilled care needs and providing protection for those home health agencies which serve the most seriously ill beneficiaries. Reimbursement reform should be based on the principle that all Medicare home health care services must be appropriate and that there must be neither overutilization nor underutilization of medically necessary covered care.

AFHHA believes that home care is not the problem. Home care is a big part of the answer.

I. PRESERVE THE INTEGRITY OF THE MEDICARE PROGRAM

Medicare reform legislation must preserve the integrity of the Medicare program. Any restructuring must contribute to the quality of care, enhance consumer choice, preserve the small business health care infrastructure, and make financial sense for the Medicare Trust Fund.

Many policymakers look to managed care as a solution to rising Medicare expenditures. Greater reliance on managed care must ensure that older and disabled Americans retain their right to:

- remain in traditional Medicare;
- choose their physicians and other providers of health care services; and
- choose among appropriate types of health care services.

Beneficiaries could in effect be forced out of fee-for-service (FFS) Medicare into Health Maintenance Organizations (HMOs) and other types of managed care if it becomes financially impossible to remain in the traditional program because of high-

er premiums and greater out-of-pocket costs. Traditional Medicare would become a truncated and high cost sector that only a very small percentage of higher income beneficiaries would be able to afford. The small business health care infrastructure would also be imperiled. Few providers would be left to serve the traditional Medicare population, having moved to managed care networks or been driven out of business altogether.

Managed care Medicare must preserve, not eliminate, consumer choice and competition. It is the very existence of consumer choice and vigorous competition that has motivated providers and health care plans to compete not only on the basis of price, but also on quality of services, outcome of care, technological and service innovation, and consumer satisfaction.

Beneficiaries already have the choice of joining HMOs but the vast majority choose not to. They remain in traditional Medicare because the program serves their health care needs well as they age and their health fails. An article in the October 12, 1997, issue of the Journal of the American Medical Association reports on a four-year study which indicates that "For elderly patients (those aged 65 and older) treated under Medicare, declines in physical health were more common in HMOs than in FFS plans (54% vs. 28%)." Even worse: "Patients who were elderly and poor were more than twice as likely to decline in health in an HMO than in an FFS plan (65% declined in physical health in an HMO vs. 27% for FFS)."

Another study indicates that for home health services, outcomes are clearly superior in fee-for-service. The November 1996 edition of Continuing Care reported on a study by Dr. Peter Shaughnessy of the University of Colorado's Center for Health Services Research which indicated that while home health care is 31 percent cheaper under managed care plans than under FFS, outcomes are significantly better under FFS. Managed care provides fewer visits and produces patient outcomes which are "pervasively worse." While FFS was determined to cost an average of $1,300 over 12 weeks vs. $900 for HMO patients in the sample, FFS "very likely incurs fewer costs in the long run."

II. Make Beneficiaries' Right to Choose Their Own Providers an Enforceable Right

By law, Medicare beneficiaries have the right to choose the providers from which they receive health care services. In the current market of managed care systems and health care networks, "captive referrals" by the referring entity or professional have the effect of denying beneficiaries their right to choose the providers from which they receive services. A right for which there is no remedy when violated is a toothless right.

Congress must require that institutions and agencies which have provided care and have determined that additional services are medically necessary and covered advise beneficiaries and/or family members of their right to receive health care services, including post-hospital home care, from the providers of their choice.

Referring providers and professionals must be required to: (1) furnish beneficiaries with a list of providers of needed services in the geographic area where they live; (2) specifically disclose the nature of any financial or control relationship with providers appearing on the list; (3) specifically state that consumers do not have to choose providers having a financial relationship with the referring entity; and (4) obtain a written statement from beneficiaries and/or family members acknowledging receipt of this information.

We urge action on "The Patient Freedom of Choice Act of 1997," introduced by Congressman Pete Stark to ensure beneficiaries' right to choose their providers of health care services.

III. The Growth of the Medicare Home Health Benefit is a Great Success Story for Beneficiaries and Congress

Both Congress and the Clinton Administration have expressed concern about the recent growth of the Medicare home health benefit. Rather than regard this growth as a problem that must be attacked with artificial utilization controls, Congress should build on the great success of the home care benefit.

Hospital prospective payment (PPS), implemented in 1984, has worked just as Congress intended. It has resulted in the discharge of Medicare beneficiaries to the home and other outpatient settings more quickly and in a poorer state of health.

The growth of the Medicare home care benefit stems from a variety of factors, primarily:

1. Reimbursement changes leading to the early discharge of Medicare patients from hospitals;

2. Technological advances which have given home health agencies the ability to provide all health services short of surgery in the home;

3. The aging of the American population, as well as an increase in the average age of home health recipients, which is now approximately 79 years of age;

4. Strong family and patient preference for cost-effective family-oriented home care services; and

5. A 1988 Federal court decision (Duggan v. Bowen) that reversed restrictive Federal policies which denied home health services to a number of otherwise eligible beneficiaries on the claim that they were in effect "too sick" for home care.

A study in the Fall 1994 issue of the Health Care Financing Review ("A Profile of Home Health Users in 1992," Mauser, Miller, Fall 1994, pp. 17–33) indicates that higher utilization of Medicare home health services is directly related to:

- the number of medical conditions and diagnoses a patient has ever had;
- patients who have three to five deficiencies in activities of daily living (ADL):
- beneficiaries who live alone;
- racial minority status;
- low income, as indicated by Medicaid eligibility, which in turn is related to poorer health status and higher morbidity; and
- the number of nursing home beds is the community—home health utilization is higher in communities with fewer nursing home beds.

In the same issue of Health Care Financing Review, the research organization Mathematica also corroborates the link between the number of nursing home beds in a community and home health utilization, stating: "... (I)f nursing home beds are scarce, beneficiaries are more likely to use home health care (either while awaiting nursing home placement or instead of nursing home placement). Similarly, if hospitals have very high occupancy rates, they may be inclined to discharge patients sooner and with greater post-hospital home health needs than otherwise."

Mathematica adds: "In addition, alternative providers (such as nursing homes) may be unwilling to serve a particular type of patient (for example, ventilator-dependent patients or patients with dementia) if they do not perceive themselves as adequately compensated for caring for that type of patient or if they do not have the specialized resources the patient needs. Care for some of these patients may then fall to home health agencies, if the patients also have skilled needs."

Home health care is cost effective even for the most frequent users of services—those beneficiaries who receive more than 150 visits per year. According to Mauser and Miller, for this category of patients, the average number of visits received in 1992 was 250, and the average total reimbursement was $12,276.00.

We contend that this is a great cost effective bargain for the American taxpayer. A patient requiring 250 visits a year is a very sick patient. If such a beneficiary is unable to get vital services in the home, he or she will end up in an institutional setting at a much greater cost to the Medicare program and the American taxpayer. Hospitals and skilled nursing facilities could not begin to provide substitute care at anywhere near the home health agency's level of cost effectiveness.

IV. Enact a Prospective Payment System for Home Health Which Preserves Beneficiary Access to Care

The Administration's Fiscal Year 1998 budget contains a uniquely punitive proposal for interim steps towards enactment of a prospective payment system (PPS) for home health in 1999. The legislative language of the President's plan calls for reimbursing home health agencies, beginning October 1, 1998, the lower of:

(1) reasonable costs up to cost limits reduced from 112 percent of the mean (or average) to 105 percent of the median; or

(2) a home health agency specific per beneficiary cap based on a provider's reasonable cost of providing services to patients in 1994.

If the Secretary is able to calculate a per beneficiary cap for each home health agency, then it has the ability to implement Phase I of Rep. Nancy Johnson's proposal for a prospective payment system for home health (H.R. 4229 in the 104th Congress) forthwith.

Application of market-based principles to the Medicare home health benefit through enactment of PPS is long overdue as a means of increasing efficiency while reducing costs. The current cost-reimbursement system leaves providers subject to retroactive claims denials and cost report disallowances. While home health agencies will still be subject to medical and utilization review, we would expect that PPS would at least rid providers of most of the problems associated with the cost reporting process, including the burdensome cost report, as we know it today. Any PPS plan enacted by Congress must in fact moves home care off of cost reimbursement

and not simply tinker with the current system until such time as a pure per episode methodology is ready.

Rep. Johnson's legislation is a responsible, well-reasoned proposal. The Johnson bill is far superior to the PPS plan included in the 1995 Reconciliation bill, which was vetoed by the President. AFHHA fought to ensure that several fatal flaws of the earlier legislation were not included in subsequent proposals. (We considered these the fatal flaws of the 1995 Reconciliation bill: a 60-day break between episodes of care; calculation of reimbursement rates based on the cost of 120 days of care while the provider was obligated for 165 days of service; and no rate adjustment when a patient developed a new diagnosis while on an episode of care.)

The Johnson bill raises several concerns, however, because of provider-specific rates that will perpetuate some of the inefficiencies of the current reimbursement system. Congress should not enable even the most inefficient agencies to continue operating without changing the way they do business or enshrine base-year payment rates that may or may not be related to patient need.

At the same time, provider specific rates may be the only way we will be able to protect sicker patients and the home health agencies which serve them. In the current climate, with Congress and HCFA charging "overutilization" of the home health benefit, this may be the most viable way of protecting such patients and providers.

A prospective payment system must: (1) ensure continued access to high-quality services for the sickest patients, those requiring more intensive services and/or with long-term skilled needs, and (2) financially protect the home health agencies which care for these sicker patients.

V. Oppose Smoke-and-Mirrors Transfer of Home Health Benefit to Part B of Medicare

Enactment of the Clinton Administration's proposal to shift the bulk of Medicare home health services from Part A to Part B of Medicare would significantly curtail patient access to needed home health services and almost inevitably lead to greater out-of-pocket expenses, in the form of copayments for those beneficiaries who receive home health care under Part B, and higher Part B premiums in order to cover 25 percent of the cost of the transferred benefit.

The benefit would be returned to its outmoded pre-1980 status, when home care services under Part A were available only to patients who had a prior hospital stay of at least three days, and visits were limited to 100 annually.

When Congress removed the prior hospitalization requirement and visit limit, it did so recognizing that home health care could serve as a more efficient, less costly, and more desirable modality of care for many Medicare beneficiaries. That is what it has proved to be. As many as seven out of ten Medicare beneficiaries who use home health services today have not been hospitalized and are receiving care at home as an alternative to more expensive hospital or nursing home care.

The home health benefit has contributed to the strengthening of the Medicare program. The hemorrhage in the Trust Fund would no doubt have been even greater without the wide availability of home care. In the absence of alternate home health services, patients would have had to receive care in more costly institutional settings.

Despite fundamentally changing the nature of the benefit that has served sick elderly and disabled Americans so well for nearly three decades, the transfer from Part A to Part B would do little to strengthen the Medicare program or extend the life of the Part A Trust Fund. In fact, the Part B shift is budgetary sleight-of-hand that will produce only phantom paper savings for the Medicare program while imposing real financial burdens on some of the nation's most vulnerable elderly and disabled.

Congress must consider who would really pick up the tab for the Administration's ill-considered plan. In addition to a probable copayment, Medicare beneficiaries would effectively be forced to pay for home care services twice, once through a lifetime of Medicare Part A payroll deductions and again through a likely increase in Part B premiums, which by law are required to cover 25 percent of program costs.

If, on the other hand, the premiums will not be increased to cover 25 percent of the new Part B home health services, the American taxpayer will be forced to pick up 100 percent of the tab.

VI. Bundling of Medicare Payments Is Anticompetitive and Denies Choice to Consumers

The Administration's Fiscal Year 1998 budget seeks authority to "develop and implement an integrated payment system for post acute services," including home

health, skilled nursing facility, rehabilitation hospital, and long term care hospital services.

For several years, policymakers have introduced proposals to bundle Medicare home health and other so-called "post-acute" care services, either to hospitals, through an add-on to the diagnostic related group (DRG) payment, or to some other entity which would be responsible for arranging and paying for all services.

Bundling of post-acute care services would have serious consequences for Medicare patients and the small business health care provider infrastructure. This fundamental restructuring would:

- deny or limit patient choice in the selection of a health care provider;
- force consumers into managed care;
- restrain competition between providers and turn control of the marketplace over to a limited number of companies;
- limit the provision of medically necessary services by creating the incentive for the delivery of fewer services and less care;
- negatively affect patient health status and outcomes;
- transfer patient care decisions from physicians and consumers to case managers and gatekeepers; and
- undermine the viability of home care providers and professionals in rural and underserved areas and thereby limit access to care in those communities.

Bundling would dramatically alter and undermine the Medicare home health benefit. It would fundamentally change the relationship of home health agencies to their patients, physicians, referral sources, and payors. These changes would be deleterious to patient choice and access to home care services. Bundling would also threaten the operation and very existence of small business and independent home care providers. The entity controlling the bundled payment would be granted an insurmountable advantage over its competitors. The incentive inherent in the bundled payment would be for the controlling parties to refer patients to their own affiliated businesses in order to maximize Medicare reimbursement. This incentive would deny patients and their families their right under the law to choose their providers of health care services, and it would no doubt do so at the expense of quality, access, and cost considerations.

Many home health agencies not affiliated with the entity which received the bundled payment would be forced to close their doors. This inevitably would result in limiting access to home care, particularly for patients in outlying and underserved areas where there are already a limited number of providers.

VII. Curb Government Abuse Under Bait and Switch Operation Restore Trust

The Health Care Financing Administration (HCFA) presented Operation Restore Trust (ORT) to Congress and the American public as a program to ferret out fraud and abuse in the Medicare and Medicaid programs.

We all applaud that goal and would support a program that remained true to this purpose. In practice, however, ORT has become a case of bait and switch. The initiative targeted home health agencies (HHAs), home medical equipment companies, and skilled nursing facilities in five states (California, Florida, Texas, New York, and Illinois). Tennessee and Louisiana were added in the second phase.

HCFA intends to wind down this demonstration phase of the ORT project by March 31, 1997, and apparently will incorporate the program into the regular survey and certification process. We have been told by ORT officials that the program has paid off in $7 to $10 in recoupments for every $1 expended on ORT investigations.

What sounded good in theory has become a nightmare in practice for many providers who have faced decertification or enormous recoupment demands, without due process, without recourse to the hearing and appeals process available in other aspects of the Medicare program.

HCFA is not claiming that the providers who have been nailed are guilty of any fraud and abuse or of endangering patient health and safety. HCFA has acknowledged that ORT investigations are triggered by a provider "growing too fast" or for having a utilization rate at variance with its peers in the community, without consideration of what factors might have led to the variation. There are many valid reasons why a provider might have a utilization rate that is higher than other area providers. These include: (1) offering the full spectrum of home care services and thereby attracting more seriously ill patients, and (2) being willing to fight through the appeals process for the right of sicker beneficiaries to receive the services to which they are entitled, which peers in the community may not be willing to do. HCFA and ORT surveyors refuse to recognize the validity of Administrative Law

Judge (ALJ) reversals of denials which justify a provider's utilization practices. Success rates of 98–99 percent on appeal are common for home health agencies, yet HCFA clearly has no respect for the decisions of ALJs and accords reversals no consideration in an ORT investigation.

ORT has become a game of "gotcha" on minor documentation issues or alleged deficiencies on Medicare Conditions of Participation or standards—which at times appear to be manufactured by surveyors on the spot. The worst case scenarios have been played out in California.

ORT surveys have different protocols in each state. For instance, in California, investigations appear to be based on annual recertification surveys, not using record reviews but rather seeking to find HHAs out of compliance with the Conditions of Participation based on hyper-technical individual surveyor interpretations of law and regulation. HHAs are then decertified without a pre-decertification hearing. Providers are denied an appeal of adverse findings they would otherwise have under the regular annual certification survey rules. Normally, if the state surveyor makes an adverse finding to which the provider takes exception, the provider can appeal to the director of the state certification office. If the adverse finding is not reversed, the HHA can appeal to the HCFA Regional Office.

In Tennessee, state surveyors are doing very limited record reviews, which they concede are not statistically valid in the letters they send notifying providers of an ORT investigation. Denial percentages are then applied to a 60-day billing period to assess a recoupment. If the HHA agrees to (1) "admit" its billing error, (2) not appeal the denials, and (3) pay the assessment, apparently it will then be left alone. HCFA calls this a "consent settlement." Tennessee HHAs are not being afforded normal appeal rights on ORT survey denials, and are being told to pay or be subjected to a more comprehensive review and a larger recoupment. Failure to agree to the "consent settlement" then leads to a 100 percent review or to a "statistically valid" sample of claims with a projection of denials to the universe of claims.

The game of "gotcha" has nailed patients as well as providers. For instance, some Medicare beneficiaries in their late 80s and 90s lost their access to home health services by responding "yes" when asked if they had attended church during a period six months previously. To ORT surveyors, this signalled that all visits could be denied based on the claim that the beneficiaries were not homebound. There was no meaningful development of the homebound status with the family, physician, and home care provider, no consideration of the evidence in the record, and no regard for the fact that home health beneficiaries of advanced age are likely to be memory impaired, confused, easily intimidated—and unwilling to say they had not attended church.

Specious denials on a handful of patients are then unscientifically projected to the universe of claims, resulting in a subsequent demand for repayment of amounts ranging up to hundreds of thousands of dollars.

ORT surveys are wreaking havoc on those providers targeted, with reports that as many as 20 home health agencies have been decertified in California, representing about 50 percent of those reviewed. They are guilty of no fraud and abuse, no endangering of patient health and safety, just caught in a game of "gotcha."

VIII. Providers Must Have Rights, Too

Fraud and true abuse in health care programs must not be tolerated; but "abuse" can be a very subjective term. In cases where HCFA has charged abuse through "overutilization" of home health services, we have often seen compelling evidence of another kind of abuse:

(1) abuse of beneficiaries who face repeated denials of their care by fiscal intermediaries, denials subsequently overturned by an administrative law judge;

(2) abuse of providers who:

(A) Are labeled abusive for continuing to fight for the right of beneficiaries to receive services for which they qualify;

(B) Face loss of certification under an ORT investigation, nailed by surveyors on highly technical grounds and on incorrect interpretations of Medicare requirements, through they are not guilty of any fraud and abuse or of any practices which adversely affect patient health and safety; or

(C) May be forced into bankruptcy by a post payment sampling review, with no right to contest unspecified denials in the universe of claims and no right to completion of the appeals process before recoupment of funds.

The American Federation of Home Health Agencies believes that when an individual, corporation, or government is endowed with responsibilities, along with those responsibilities come certain associated rights. Home health agencies inform patients and their physicians not only of the patient's responsibilities but also of their

rights. Under the Medicare program home care providers' responsibilities are spelled out in:

(1) the Medicare Conditions of Participation;
(2) the Home Health Agency Manual;
(3) the Provider Reimbursement Manual; and
(4) other associated regulations.

Implicit in those responsibilities are certain rights. This would allow for benchmarking of those who monitor providers' responsibilities and should lead to correct interpretations by both providers and government officials, thus reducing the risk of liability stemming from differing interpretations.

We seek to bring balance back into the system, through enactment of legislation to hold the Federal government and its agents responsible for their own actions, especially where their errors cause harm to health care providers or beneficiaries. Congress recently enacted a Taxpayer's Bill of Rights to protect the taxpayer from the irresponsible actions of government agents. It is now time for enactment of a Health Care Provider's Bill of Rights to protect providers from the irresponsible actions of that same government.

AFHHA urges Congress to enact this Bill of Rights into law:

HEALTH CARE PROVIDER BILL OF RIGHTS

I. HCFA shall issue written clarification regarding the purpose of Operation Restore Trust. Clarify whether its purpose is fraud and abuse detection, validation of intermediary application of written coverage guidelines and criteria, or other specified reason.

A provider shall not be deemed "abusive" and therefore subject to ORT investigation because of a practice of exercising appeals rights as an appointed representative of beneficiaries or on its own behalf.

HCFA must develop written procedures and policies which include:

- written criteria for selection of providers for an ORT investigation;
- full disclosure to the provider at the beginning of an ORT investigation of the criterion under which it was selected;
- a process for a provider to appeal its selection for an ORT investigation to an administrative law judge;
- a code of behavior for surveyors;
- a protocol for review of a plan of correction; and
- full disclosure of findings during an exit interview, with opportunity for the provider to submit additional documentation and other pertinent evidence.

Resurveys shall be limited to a determination of whether problems identified in the initial survey have been addressed and shall not involve selection of new cases for review.

II. A provider has the right to appeal prior to recovery of reimbursement or decertification in any dispute involving ORT, post-payment sampling, or other HCFA audit and survey activity, unless HCFA demonstrates in writing that the health and safety of patients are at risk. HCFA must inform providers in advance in writing of what types of violations will lead to revocation of certification.

III. A provider has the right to a comprehensive exit interview with a HCFA contractor in conjunction with any activity involving ORT, post-payment sampling, or other HCFA audit and survey activity.

IV. Decisions of an Administrative Law Judge and the Provider Reimbursement Review Board are precedent setting for a provider or beneficiary except where the intermediary can demonstrate substantially different circumstances.

V. Claims denials and cost report disallowances are dependent upon the HCFA intermediary's or surveyor's ability to document that providers were fully informed, in writing, in advance, of pertinent existing policies. All policy changes, including interpretative rules, must be published in the Federal Register as final rules before applying them in any surveys. The position of the government is presumed to be not substantially justified if HCFA or agents acting on its behalf do not follow published guidelines and procedures.

VI. HCFA shall not base measurement of contractor performance of the audit function, post-payment sampling, or ORT investigations on disallowance quotas or recovery ratios, or reward contractors with a percentage of the amount recouped.

VII. Based on an extension of the principle of the new Taxpayer Bill of Rights, providers and beneficiaries are entitled to recoup up to $1 million in damages when HCFA or its agents cause harm through a violation of a provider's or beneficiary's rights.

Statement of American Occupational Therapy Association, Inc., Bethesda, Maryland

Post-Acute Care Under Medicare Part A

AOTA represents 59,000 members, a substantial proportion of whom work with Medicare beneficiaries in hospitals, home health agencies, rehabilitation hospitals and agencies, skilled nursing facilities, outpatient clinics and other settings. As the professional association representing occupational therapy practitioners we are committed to the provision of those services by properly trained professionals and to assuring that those professionals are able to practice within an ethical framework which serves the best interests of patients.

The percentage of Medicare payments being spent on post-acute care in the Part A program has been increasing. (Medicare Spending on Post-Acute Care Services: A Preliminary Analysis, Congressional Budget Office, January 1997) Many analysts have attempted to understand the reasons for this change, to document the appropriateness and effectiveness of the care provided, and to determine whether this increase is a positive change. In addition, the necessity for cost containment and fiscal responsibility have encouraged examination of the relationship between the growth in post-acute care and changes in hospital acute care utilization and costs.

AOTA recognizes the need for constraining costs under the Medicare program and stands ready to work with Congress and the Administration to address post-acute care costs for skilled nursing facility (SNF) and home health (HH) services while maintaining high quality services for beneficiaries.

- AOTA supports closer examination of post-acute care services in order to assure the longevity of the Hospital Insurance Trust Fund and to promote responsible spending under Part B. However, changes to this complex system without adequate examination, analysis and consideration of quality issues could endanger beneficiary health and well-being.
- AOTA supports movement to prospective payment systems for skilled nursing services, home health and rehabilitation/long term care hospitals. However, these must be approached with caution and due concern for patient well-being.
- AOTA recommends that design of such systems must take account of a number of critical factors, including eligibility criteria, desired service outcomes, service decisionmaking, personnel qualifications and quality monitoring mechanisms to assure patients receive appropriate services.
- AOTA does not support integration or bundling of payment for these post-acute care benefits at this time. Such an approach has not been well analyzed or demonstrated. Both harm to beneficiaries and inappropriate influences on health care market structure could result.
- AOTA supports improving and enhancing data collection, including the use of standardized coding for all nursing, therapy and other skilled nursing facility and home health services to determine the appropriate mix of services and payment levels as well as to monitor quality.

Skilled nursing facility and home health patients receive services to recover from illness or injury and to prepare to return to more independent functioning. If they recover inadequately or are denied services which can assure recovery or a safe return home, they may require further hospitalization or skilled nursing facility care. Providing for the proper type and intensity of therapy services is key to avoiding subsequent costs and we believe this requires continuing development, testing and monitoring.

Occupational Therapy in the Post-Acute Sector

Occupational therapy is an important component of the post-acute care services provided under the Medicare Part A benefit.

Occupational therapy is a health and rehabilitation service, provided by licensed or certified professionals, which uses goal-directed activity in the evaluation and treatment of persons whose ability to function is impaired by illness, injury, disability or normal aging. Treatment goals in the post-acute setting include maintaining, regaining or improving maximum function, adjustment to impaired function, prevention of further injury or complications, and increase in independent activity.

In the post-acute care setting, occupational therapy is provided in the treatment of individuals with a variety of diseases, conditions or functional limitations, including the following:

- Cerebral vascular accidents (stroke)

- Alzheimer's Disease
- Cardiac conditions
- Arthritis
- Parkinson's Disease
- Cancer
- Hip fractures
- Amputations
- Neuromuscular conditions
- Multiple Sclerosis
- Cerebral palsy
- Arteriosclerosis

Occupational therapy practitioners evaluate patients' disabling conditions and functional limitations. A treatment plan is developed to ameliorate the condition, improve or regain function, and achieve as full recovery as possible. Occupational therapy is provided to:

- Remedy, prevent or reduce disability through interventions which increase joint motion, muscle strength and coordination, and balance, e.g., following a hip replacement.
- Through therapeutic adaptations such as assistive equipment and physical environmental modifications, promote mobility and enable the individual to be as independent as possible by overcoming the limiting effects of a physical, mental or visual condition, e.g., following a stroke.
- Provide education and retraining through special, individually designed techniques and methodologies to assist the patient to perform essential and instrumental activities of daily living such as feeding, dressing, personal hygiene, and meal planning to increase the independence of an individual and speed recovery of function.
- Provide sensorimotor treatment for strengthening, endurance, range of motion, coordination and balance, e.g., following a cardiovascular accident.
- Analyze capacity and improve ability in thinking and analysis through therapeutic activities for memory, orientation, cognitive integration, and decision-making, e.g., for an individual with Alzheimer's disease or Parkinson's disease.
- Analyze need for and implement programs for safety techniques to avoid injury for individuals such as women vulnerable to broken hips from falls, e.g., an individual with osteoporosis or weakened by treatment for conditions such as cancer or pneumonia.
- Provide analysis and implementation of programs to enable cardiac and other patients with limited physical reserve to perform daily activities with limited expenditure of energy.

Occupational therapy's theoretical underpinnings are based on the physical and psychological implications of illness, injury, disability and aging, and on analysis of the components of activities or "occupations." The clinician's knowledge of adapting tasks and modifying the environment to compensate for functional limitations, combined with training in anatomy, physiology and related disciplines, is used to achieve recovery and improved function.

Current Service Design: Skilled Nursing Facilities and Home Health

Skilled nursing facility services are an important component of Medicare Part A Coverage. These services provide the post-hospital patient the skilled services that are necessary to recover from illness or injury and to regain optimal levels of health and function.

Under Medicare Part A, beneficiaries are entitled to 100 days of SNF care following a minimum three-day hospital stay. In order for a SNF stay to be covered under Medicare, the patient must need daily skilled level services provided by a registered nurse, physical therapist, occupational therapist, or speech-language pathologist, as determined by a physician. After the 20th day of a SNF stay the beneficiary is liable for a daily co-payment equal to $95.50.

Home health care is provided under Medicare Parts A and B. Occupational therapy is available to patients who first qualify for home health by needing skilled nursing services, physical therapy or speech-language pathology services. Patients must also be homebound.

In this context, occupational therapy is provided to assist individuals to improve function and thus be able to live without home services more quickly. Occupational therapists analyze the individual patient's needs in their home environment and increase ability to provide for self care.

There are no co-pays and no limits on home health services other than meeting the continuing requirements for eligibility, including medical necessity and appropriateness.

Current Utilization of Skilled Nursing Facility Services

Recently, increases in the total costs of skilled nursing facility care have been highlighted along with the growth in the costs of skilled rehabilitation services—physical therapy, occupational therapy, speech-language pathology and audiology services—provided in skilled nursing facilities, with little attention to the changing nature of the patient population served by skilled nursing facilities.

It is important for policymakers to understand the profound changes in the types of patients admitted to skilled nursing facilities and advancements in the practice of the skilled therapies that produce improved patient outcomes. Without a complete understanding of these factors, legislative reforms aimed primarily at cost control can undermine the quality and effectiveness of post-acute rehabilitation therapy. The following factors are critical to understanding the nature of skilled nursing facility services today:

- The adoption of a prospective payment system for hospitals has dramatically shortened hospital stays, and produced a patient population with higher needs for post-acute skilled care some of which in the past may have been initiated during a hospital stay.
- Since 1987, the number of overall patient days in skilled nursing facilities has more than tripled—7.4 million days to 36.9 million days—accounting for most of the growth in total Medicare skilled nursing facility spending; the overall number of Medicare beneficiaries has also increased from 31 million in 1985 to more than 38 million in 1996.
- While overall ancillary service charges have risen, much more therapy has been provided because such therapy was required by Congressional mandate and court decrees.
- The nursing home reform standards enacted by the Omnibus Budget Reconciliation Act (OBRA) of 1987 imposed new screening and service-specific standards on skilled nursing facilities that have required more attention to the improvement or maintenance of mental health and the capability to perform activities of daily living. Implementation of these standards has raised the costs of skilled nursing facility care.
- The case of Fox v Bowen (US District Court, District of Connecticut, April 1986) held that each patient's medical condition and therapeutic needs were to be taken into consideration in determining need for services such as occupational and physical therapy. One related effect has been that each patient admitted to a skilled nursing facility is evaluated for rehabilitation needs and appropriate services are to be provided.
- More effective regimens for the rehabilitation of the post-acute patient are producing better outcomes in terms of higher levels of function, lower re-hospitalization rates, and return to the community. (Studies showing this include "Outcomes of Enhanced Physical and Occupational Therapy Service in a Nursing Home Setting," Archives of Physical Medicine and Rehabilitation, Vol. 77, June 1996, pp. 554–561 and "Patient-Level Cost of Home Health Care Under Capitated and Fee-for-Service Payment," Inquiry, 32:252–270, Fall 1995.)

Current Utilization: Home Health Services

There are similar factors which affect the increased utilization of home health services.

- The Omnibus Budget Reconciliation Act of 1980 eliminated the hospital stay requirement under Part A for home health, the Part B deductibles, and the 100 visit limits under both A and B. This deliberate action to make services available to those who need them contributed greatly to the increase.
- Changes in age composition, growth in the Medicare population, advances in technology for home-based care, and changes in acute care payment have also affected increases.
- Need for home health services is not related only to acute health conditions or simply diagnosis. Even the Prospective Payment Assessment Commission in its testimony before the Ways and Means Committee's Subcommittee on Health on March 5 noted that in home health "patients' service needs often depend on multiple factors. For example, functional status and social support needs may be more important than diagnosis in predicting resource requirements for home health patients."
- The changing pattern of service use tends toward extended services of home health aides rather than skilled care, reflecting a changing purpose for home care.

Rather than acute care, it has moved to respond to an unmet need for patient's with chronic conditions.

While all of these factors contribute to the growth in Medicare costs for the home health patient, there is a measurable return on this investment in reducing future costs and in the improved quality of life for patients treated. Medicare beneficiaries are living longer and also want to maintain functional independence longer. Supports such as appropriate post-acute care contribute to these goals.

Current Payment Methods: Problems and Limitations

Under Medicare, skilled nursing facilities are paid on the basis of their reasonable costs for providing routine and ancillary services. Routine service costs including room and board, professional nursing services and a portion for facility overhead are subject to cost limits. Ancillary services which include the skilled therapies (physical and occupational therapy, and speech-language services), radiology, pharmaceutical and other supplies are also paid on a reasonable cost basis but are not subject to cost limits.

In the case of therapy services, skilled nursing facilities may provide these services directly through employees or under contractual arrangements with independent therapy providers. In either case, the costs of these services are included in the facility's ancillary cost category. Medicare law requires that these costs meet a reasonableness standard. For physical therapy and respiratory therapy provided under arrangements (i.e., contract), Medicare uses a salary equivalency formula as a proxy for comparing what it would cost to employ the therapist to meet the reasonableness test; for the other skilled therapies, Medicare applies a "prudent buyer" test in reviewing the appropriateness of therapy charges provided under contract.

It is important to recognize that this differential treatment of the costs of therapy services has resulted in different levels of charges and payment. costs. The Government Accounting Office (GAO) has reported on what they characterize as "overcharges" for therapy services. AOTA strongly condemns exploitation of the Medicare program by dishonest or unscrupulous individuals or companies but also is concerned that accurate analysis of problems be conducted.

Distinctions must be made between verified billing abuses and legitimate increases in utilization of therapy services in nursing facilities which meet the rehabilitation needs of Medicare beneficiaries and are authorized through Congressional and Health Care Financing Administration initiatives. Charges for therapy services which are submitted as claims do not reflect what providers are paid; charges are generally much more than the reimbursement providers receive. Further, Medicare payment rules governing the delivery of therapy services in nursing facilities are exceedingly complex, cumbersome and outdated.

The relationship between physical and respiratory therapy payment under salary equivalence standards and payment for occupational and speech-language therapy under a "prudent buyer" standard must be examined. Under these two systems, what is considered allowable time differs, as do allowable related costs (e.g., administrative costs). The formula for determining the allowable costs for contract physical and respiratory therapy includes all of the hours that the therapist spends in the facility while for the other therapies, including occupational therapy, only those hours spent in direct patient care are counted. These differing payment policies and rules account for much of the variance of the rates charged for skilled therapy services under Medicare. These payment policies account for much of the differences in the rates charged for the various skilled therapists.

These factors must be well understood when examining data on therapy charges and in designing any changes to the system.

In home health, payment is made on a per visit basis to certified home health agencies. Payment is made on the basis of agency costs or a limit based on 112 per cent of the average cost per visit for each of the service-type visits—these visit rates, therefore, reflect both patients with limited problems and those with more extensive impairments. These visit limits are not case-mix adjusted.

A critical data and monitoring problem is that a visit length and purpose are not defined or reported under Medicare. This is perhaps the major problem in developing a prospective payment system with quality goals. Further data collection and analysis are needed to define appropriate service levels for different types of cases.

Prospective Payment: Need for Accuracy, Accountability, and Quality

Prospective payment systems can create desirable incentives for more efficient and economical behavior as well as increased predictability of costs; however, there can also be significant risks to the accessibility and quality of services. Therefore, such efforts must be made based on adequate data and include quality monitoring

standards. Such an approach must support improved patient outcomes and assure patient access to necessary and appropriate care. Any system for skilled nursing facilities, home health, or rehabilitation/long term care hospitals must be carefully designed, tested, implemented and monitored to assure the systems serve patient needs as well as fiscal goals.

Prospective payment can create incentives for under-service. In the post-acute environment, many of the skilled professional services—including the services of occupational therapists—are provided under arrangements with skilled nursing facilities and home health agencies. Payment incentives for skilled nursing facilities and home health agencies could result in inappropriate limitations on these critical services unless there is careful monitoring of patient access to needed services.

The challenges of structuring prospective payment systems are substantial obstacles to moving forward despite relatively broad consensus on the desirability of such an approach. The heterogeneity of the patients treated in skilled nursing facilities and home health, the lack of reliable patient classification systems, and disagreement over outcome standards have all contributed to the delay in moving to a prospective system.

In skilled nursing facility payment, moving to a per case or episode-based payment system skilled nursing facility payment, there are a number of important considerations:

- insuring patients have access to appropriate services;
- assuring the quality of those services including assurances that services will be provided by qualified personnel;
- adequacy of payment levels to meet specific patient needs;
- linking payment with appropriate patient outcomes.

Any new payment system must incorporate current costs of the resources needed to meet patient needs including those patients who have co-morbidities resulting in the need for a more intense level of service. Wherever possible, payments should reflect "best practices" and treatment outcome data. Since the allocation of resources for patient care under a prospective payment system will be the responsibility of the skilled nursing facilities, it is critical that facilities be held accountable for providing patients access to medically appropriate therapies. Without effective accountability measures, adequate payment rates do not guarantee that patients will receive the level of care intended or have access to appropriate health professionals. Accountability must be built on adequate data reflecting thorough understanding of patient service needs and building in appropriate valuation of all necessary services. Particular care must be taken to assure that patients receive appropriate—not just least costly—services.

The same principles must be held to under a home health prospective payment system. Again, particular regard must be given in design and implementation to assuring that patients get the highest level of service they need not just the least expensive. Most of the proposals put forward or tested over the past several years have been similar, establishing per visit cost limits and aggregate agency limits. The general direction of these approaches may be suitable but any new payment system must be built around a valid classification system and a foundation that assures that services are appropriate and that they are provided by qualified individuals. Improved data collection, using standardized coding to define services and employing a more clear definition of visits, will enhance this system.

However, some proposals include an allowance for agencies to be rewarded for their cost effectiveness. Offering financial inducements or rewards to providers based on how much they save below a cost limit is a prescription for underservice and denial of patient care. Incentives for savings should not take precedence over incentives to provide appropriate care. The use of bonuses to providers to encourage savings may do so at the expense of patients. While appropriate incentives could be used to promote cost effective care, a conservative approach, carefully implemented and monitored, must be used.

Coverage of Home Health Care

A particular concern for AOTA is the use of the outdated qualifying service method for determining coverage policy regarding home health. This requirement is not justifiable under a prospective payment system. Determination of coverage should be done based on characteristics of patients and services should be targeted most appropriately and efficiently to meet those needs.

Current law with regard to home health qualifications, however, limits access and choice for consumers, places administrative burdens on providers and intermediaries, and is not cost effective in requiring additional services to be provided. Current law only allows coverage of occupational therapy as a home health

services if the patient has a need for skilled nursing services, physical therapy, or speech-language pathology services. This is inappropriate from a clinical standpoint because a patient's need for occupational therapy will not necessarily be conditional on the need for another service. Often times occupational therapy is the most appropriate and only intervention necessary to enhance a patient's functional status and enable him/her to remain independent in the home.

Current law is also flawed from a policy and program integrity perspective because it may encourage unnecessary utilization of skilled nursing, physical therapy or speech-language pathology services in order to qualify the patient to receive occupational therapy.

When a prospective payment system for home health is implemented, this limitation would unreasonably restrict choice on the part of patients and providers to select the most appropriate and effective service. A prospective payment system would include many incentives to speed a patient's recovery and discharge from home health. Prospective payment may also require a different decisionmaking process in determining which services are provided in a limited time and under constrained funding. Current Medicare law makes it difficult, and sometimes impossible, for an elderly beneficiary to get occupational therapy, which may be the only service the individual needs or which could be the key service to achieve optimum recovery for that individual. As a result, the individual's progress may be impeded, the original debilitating condition could worsen, and the possibility of costly acute care or placement in a skilled nursing facility is increased.

Occupational therapy should be an available skilled service to any patient who needs it as part of the home health benefit. Because its goals are to increase independence and functioning, it would also contribute to the effectiveness of the prospective system because it would allow agencies to provide services as soon as possible which can move a patient toward independent function and therefore less need for supportive home health services.

A change in the overall approach to coverage would allow occupational therapy to be defined as a qualifying service or to otherwise restructuring the threshold requirement for eligibility for home health services would allow people who need only that service to receive it directly without requiring receipt of another service. Medicare law clearly supports occupational therapy as a free-standing, critical home health service. Occupational therapy can continue to be provided after the need for the qualifying service (physical therapy, skilled nursing, or speech-language pathology services) has ended.

In addition, occupational therapy may be underutilized in the current home health system (accounting for only small percentage of the total visits) because of this skewed eligibility criteria; yet, occupational therapy is an essential service directly targeted at improving independent function and decreasing need for services such as home health aides. To better understand appropriate services and to better predict utilization, AOTA recommends that a demonstration project be done using coverage criteria that allow occupational therapy as a qualifying service or an eligibility system which uses an alternative to the qualifying service approach to determine the effects on costs and outcomes. Such a project could examine the current eligibility criteria and provide better information on which to build a prospective system.

To endorse a radical change to the payment system while ignoring other problematic aspects of the home health benefit perpetuates the piecemeal approach which underlies many of the problems we now face in the Medicare system.

Payment System Design Issues

A patient classification system is an essential tool for grouping patients with similar conditions and expected requirements for care. Any such system must:

- consider a broad spectrum of patient characteristics including the patient's diagnosis, other medical conditions, functional limitations, need for services, and outcome potential;
- assure that cases or episodes are relatively homogeneous with respect to the professional services required; and
- provide for a data reporting system that permits appropriate monitoring and measurement of the quality and outcomes associated with its use.

One example of such a classification system is the resource utilization groups (RUGs) which is currently being used in a prospective payment demonstration program involving skilled nursing facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas. Phase III of the demonstration incorporates payments for therapy services into the prospective daily rates. However, at this point, it is not clear whether RUGs will be adequate for use as a payment tool or whether the

project will yield sufficient information to design a nationwide prospective payment system for skilled nursing facilities.

As prospective systems are designed, patient goals must be defined and incorporated into the monitoring system. Previous proposals from Congress and the current proposal from the Administration contain no desired or expected patient outcomes for either home health or skilled nursing care. These are not mentioned as part of the overall approach to improve the payment system. Cost effectiveness improvements must be linked to patient outcomes. Episodes of care or levels of reimbursement must be designed with quality care and achievement of optimal health and functional outcomes as paramount objectives.

Quality monitoring mechanisms or expectations must also be outlined to assure that funds are equitably allotted to patients based on patient need and establishment of desired patient outcomes. Control and monitoring of quality of care and patient outcomes are not inconsistent with prospective payment; indeed if a system is built based on identified patient need, more cost effective services will be provided.

Need for Improved Data Collection

A problem highlighted in the ongoing reporting and analysis of the Prospective Payment Assessment Commission and others is the problem with current data. Under both the skilled nursing and home health benefits, data about what constitutes a visit or treatment session, what interventions are performed and how much time is spent are virtually non-existent. This lack of data will limit the appropriateness of any prospective payment system. Improved and enhanced data collection must precede the implementation of a prospective payment system and must also be used to monitor implementation. Services in skilled nursing facilities—both routine and ancillary—are not well documented or measured under the current system. Such information must be captured if an appropriate patient classification system is to be developed.

AOTA supports the proposals put forward by the Administration and others to require coding for procedures provided in skilled nursing facilities and would recommend extending that requirement to home health services. Nursing, therapies, and other services should be recorded using consistent coding (e.g., use of HCPCS for therapies) to better understand current services, to develop a reliable prospective payment system with a solid patient classification system, and to effectively monitor quality of care after a prospective payment systems is put into use. It is important to extend this coding through some mechanism to nursing services. These services are significant in the request for exception payments under the current skilled nursing facility payment system and thus should be better analyzed. Nursing and nurse aide visits also comprise a majority of home health visits.

AOTA also supports the Administration's request for authority to require reporting of additional data from post-acute care providers.

Summary

Changing the payment system for post-acute care should proceed gradually with appropriate transitional periods to avoid unnecessary disruptions for patients and providers. Prospective rates should also include categories for outlier or exceptional cases, for changes in technology, advancements in therapeutic practices, and a reasonable allowance for inflation. Finally, parallel to any implementation plan for prospective payment must be an evaluation component so that appropriate mid-course corrections can be made.

Although we have not been privy to legislative language details, the information we have had thus far forces us to express serious apprehension about the potential impact on patient care of the proposals to implement prospective payment systems for home health and skilled nursing facility services under Medicare. While we reiterate our support for the concept, we also reiterate our concerns about implementation on too rapid a timetable.

In particular, we are strongly opposed to the Administration's request for authority to implement new payment methodologies and to integrate payment systems without further legislative oversight. AOTA believes that this request denies the Congress its appropriate role in designing both the benefits and payment approaches for the Medicare program.

AOTA is ready to assist the Congress to better understand the importance of these benefits and the complexities of payment. We are eager to work on the important issues of assuring appropriate cost containment while assuring quality patient outcomes.

Contact person: Christina A. Metzler, Senior Legislative Representative

Statement of American Physical Therapy Association

The American Physical Therapy Association (APTA), a national membership association representing over 72,000 physical therapists, physical therapist assistants and students of physical therapy, appreciates the opportunity to submit comments on Medicare skilled nursing facility, home health care and other post-acute care payment policy.

The APTA commends the Ways and Means Subcommittee on Health for holding a hearing on these important issues. We strongly support reasonable Medicare reform which ensures the viability of the program while maintaining quality of patient care and access to needed services, such as physical therapy. This testimony serves to: 1) provide background on the growth of post-acute care; 2) describe the APTA's position with regard to the changes in Medicare payment policy that are being recommended by the administration and other parties; and 3) make recommendations on payment reform.

Background-Growth of Post-Acute Care

There has been significant growth in the Medicare program in the last five years in delivery of post-acute care services. A number of factors have contributed to this growth, including change in payment policies, court decisions, and demographics. Part of this growth can be attributed to the implementation of the prospective payment system in 1983 for inpatient acute care hospitals. Under this system, patients are classified into diagnostic-related groups (DRGs) and hospitals are paid a set amount at discharge for the patient based on the DRG. The hospital receives the full DRG payment regardless of the time of discharge. As a result of this payment system, inpatient hospitals have financial incentives to discharge patients from the hospital "quicker and sicker" than they had in the past. Patients are discharged to post-acute settings, such as skilled nursing facilities, rehabilitation hospitals, and their homes, where they receive care. In these settings there has been an increasing demand for rehabilitation services such as physical therapy, as there is wide recognition of the improvements that patients can make in their condition by receiving physical therapy. Physical rehabilitation helps individuals achieve their maximum level of functional independence; the return on investment of physical rehabilitation is positive as long-term institutionalization is reduced or avoided.

The APTA strongly believes that action needs to be taken to preserve the Medicare Trust Fund and supports some changes in payment policy that would achieve this goal. The position of the APTA on some of the proposals that have been put forward recently to constrain growth in the Medicare program are discussed in the following paragraphs.

Skilled Nursing Facilities: Prospective Payment System

The President's Fiscal Year (FY) 1998 budget recommends implementing a prospective payment system (PPS) for skilled nursing facilities (SNFs) by July, 1998. The APTA supports the development of a PPS for SNFs utilizing payment rates rather than cost limits. If properly implemented, a PPS under which payment rates are set in advance can encourage the efficient provision of quality care. However, the APTA has some concerns regarding the development of the patient classification system upon which a PPS would be based.

Lack of Adequate Data

The critical component of a PPS for SNFs is the case-mix measure or patient classification system that is used to ensure that a facility is paid sufficiently for the necessary resources required. There is currently a lack of adequate data on any patient classification system or case-mix measure to be used in a prospective payment system. Under a PPS, the patient is typically classified into a group based on certain characteristics (i.e. clinical diagnosis, age, functional ability) and the facility is paid based on the group in which the patient is placed. It is critical that patients be classified into groups that accurately measure the resources required to adequately care for the patient while in the facility. If patients are not classified appropriately, financial incentives may dictate patient care rather than patient needs.

The Health Care Financing Administration (HCFA) is currently conducting a nursing home case-mix demonstration project, referred to as RUGs III, in six states to determine payment for SNFs. The system involves using resident assessment data (minimum data set or MDS 2.0), to place patients into resource utilization

groupings (RUGs) to determine the amount of payment the facility will receive. During the first year, only routine costs were paid prospectively. In August, 1996, HCFA began phase III of the demonstration project, which involves updating the classification system to include rehabilitation and accounting for changes in the MDS 2.0. The APTA supports the project, but is concerned that the data necessary to develop an accurate case-mix measure will not be collected and properly analyzed by July, 1998. Collection of data on the use of rehabilitation services has just started. In addition, the patient assessment tool, MDS, needs considerable refinement to ensure accuracy of classification and usefulness of information.

Thus, the APTA urges Congress and the Administration to proceed slowly and carefully with the establishment of PPS for SNFs and to consider revising the proposed dates for implementation, primarily because of this lack of accurate data. HCFA needs sufficient time to collect data on a national basis, so prospective payment can be a fully integrated and validated system. Bruce Vladeck, HCFA Administrator, concurs with APTA's assessment. He recently stated in testimony that "a good PPS is better than a cost-based system, but a cost-based system is certainly better than a poorly-designed PPS without an appropriate case-mix adjuster." He also stated that "developing and testing" is the key.

In his testimony, Joseph Newhouse, Chair of the Prospective Payment Assessment Commission (ProPAC) stated that "the ability to adjust prospective payment rates for differences in case-mix is critical to ensuring fair payment to providers and access to services for patients. Without an adequate case-mix adjustment, prospective payment could unduly reward providers that treat low-cost individuals and penalize those that treat patients with more complex needs." Such an adequate and accurate case-mix adjuster is simply not available now and will not be by July, 1998.

Consolidated Billing

The administration is proposing to require that SNFs bill for all Part A and Part B Medicare services provided to their Medicare residents, except for physician services; the APTA opposes this proposal. This consolidated method of billing could result in decreased access to care for the patient who requires rehabilitation, thus potentially resulting in a decrease in quality of life. The nursing home's priority would become the cost and complication of administering both Part A and Part B, not the care of the patient. Also, consolidated billing has not been scored as a savings and does not facilitate data collection for the establishment of a SNF PPS. Congress, along with HCFA, needs to fully evaluate how such a system would work and share this with appropriate provider and patient groups.

In addition, HCFA recently indicated that it is attempting to identify what is being provided in a nursing home and being paid for under Part B for SNFs. HCFA is having difficulty determining this because the two computer systems for Part A and Part B are separate and incompatible. If this data cannot be generated and analyzed in a timely manner, it adds to the difficulty of implementing PPS by July, 1998.

Home Health Agencies: Prospective Payment System

The President's budget proposes implementing a PPS for home health agencies (HHAs) by 1999. The APTA supports such a prospective payment system but has the same concerns about the lack of an adequate case-mix measure. HCFA is looking to use selected items from the Outcomes and Assessment Information Set (OASIS) to classify patients. The demonstration project is currently being conducted in 50 facilities and the collection of data is in its early stages.

One drawback to implementing a PPS for home care is that there is considerable confusion over how a definition of "visit" for home health patients is defined. Until HCFA determines what services a patient receives in a home health visit, it makes it extremely difficult to develop a prospective payment system. The APTA urges Congress and the Administration to ensure that sufficient data is collected on a case-mix measure before implementing PPS for home health care.

Long Term Solutions

In the long-term, the APTA supports HCFA's proposal to develop a "beneficiary-centered" system upon which an integrated post-acute care payment methodology could be based regardless of site of services. The APTA strongly believes that a patient classification system that could be used across sites could be developed, with the result being better coordination of care across all delivery sites. Ideally, a core assessment tool could be used to determine patient needs across all post-acute set-

tings. Transfers among patient care settings should occur only when medically appropriate and not because of Medicare payment policy. If outcomes are determined to be the same in different settings, the patient should have some freedom to choose the setting. The core patient assessment tool could provide or enhance that freedom.

The APTA is interested in and willing to assist in the development of a core patient assessment tool upon which a PPS can be predicated. An accurate and valid patient classification system could and should serve as the basis for a beneficiary-centered PPS for post-acute care.

Home Health: PPS Work Group

With regard to reform of payment policy for home health agencies, the APTA supports the PPS plan proposed by The Home Health PPS Work Group, which includes the following:

A. A per visit PPS rate, by type of visit (e.g., physical therapy), equal to the national average per visit payment rate, but with the labor portion of the rate adjusted by the hospital wage index;

B. A national rate that would be equal to the national average amount paid per visit (including medical supplies) during the HHAs most recent cost reporting period, updated for inflation by the home health market basket percentage increase for each year prior to implementation;

C. HHAs could receive payments in excess of the rates under certain circumstances;

D. For Phase I, in year one, an aggregate per patient limit for each home health agency would be a 75/25 blend of agency-specific/census region average costs, updated by the home health market basket percentage increase to the year in which the limit applies, and multiplied by the home health agency's unduplicated Medicare patient count. In year two, the blend would be 50/50;

E. For Phase II, aggregate per episode limits covering up to 120 days of care (a 45-day gap in services would trigger a new episode) would be used, together with annual per patient limits for other services. The 45-day gap should be flexible to allow for special cases, such as being admitted to the hospital for a totally new diagnosis.

- The per episode limits would be calculated by multiplying the average number of each type of visit provided to each case-mix patient category by the applicable per visit payment rate for each service type. However the Association's support for this concept is on the condition that the Association has input into the development of the case mix methodology.
- The annual per patient limit would be based on a 50/50 blend of agency specific/census region average reasonable costs updated by the intervening home health market basket percentage increase;

F. In any year where payments to an agency exceed the applicable limit, HCFA would reduce the following year's payments to recoup the difference;

G. The Secretary of Health and Human Services would be required to submit a new per episode prospective payment proposal to Congress within four years with implementation to occur within 12 to 18 months of the proposal's submission.

Shift From Part A to Part B

The APTA also concurs with the home health industry in its opposition to the Clinton Administration's plan to shift the financing of home health care from Medicare Part A to Part B. The Association believes that this is simply an accounting maneuver does not produce any real savings. In fact, it only extends the life of the Part A Trust Fund for about two years and Part B Services would still need to be paid for out of the general fund. Further, it could add cost and complexity to the benefit, since Part A and Part B have different billing and administrative procedures, making fraud and abuse more difficult to detect.

Bundling

The APTA opposes the bundling or linkage of post-acute services payment into the hospital DRG and commends the Clinton administration for taking the same position. We believe that bundling would create an uneven playing field because of the potential hospital domination of post-acute care providers, potential incentives for patient skimming and underservice and potential loss of freedom of choice by patients. In addition, hospitals may not have sufficient knowledge or expertise in all aspects of post-acute care, making it difficult to manage the entire episode of care.

Salary Equivalency

Until PPS is enacted, the APTA supports the use of salary equivalency for SNF contract therapy services on the condition that salary equivalency be rebased for physical therapy and extended to occupational therapy and speech-language pathology. We understand that the proposed guidelines are presently at the Office of Management and Budget for review. We urge HCFA to publish this long-delayed proposed rule as soon as possible.

Three-Day Hospital Stay

The APTA supports the reduction or elimination of the three-day hospital stay as a prerequisite for Medicare coverage for SNF patients and encourages HCFA to test the validity of the rule. At the very least, we believe that this rule may be a barrier to determining the most appropriate and necessary length of stay.

Other Regulatory Reform

It should also be mentioned that there are numerous other measures that can be addressed in an effort to make the Medicare program more solvent and efficient. Bureaucratic requirements can and should be simplified or eliminated when (and in some cases even before) a PPS is implemented. These would include the need for physician referral for physical therapy, including the certification (and recertification) of the plan of care. Likewise, the requirement that a Medicare patient be physically seen by the physician at least every thirty days in order for physical rehabilitation to continue should be eliminated. These types of overly prescriptive bureaucratic requirements are obsolete in a modernized Medicare system. They add to the cost of providing care, detract from the efficient and effective way of delivering high-quality physical therapy and are a proven burden to the provider community, the patient population and indeed, the Medicare system alike. APTA stands ready to work with HCFA and the Congress toward development of a streamlined and effective methodology of providing care in a modernized Medicare system.

Summary

The APTA thanks the Ways and Means Subcommittee for providing this opportunity to state our positions on prospective payment and other issues as the Committee moves forward in trying to solve the critical problems of the Medicare system.

Contact: Pamela Phillips, Senior Lobbyist, American Physical Therapy Association

Statement of Health Industry Distributors Association

The following statement is submitted to the House of Representatives Committee on Ways and Means, Subcommittee on Health on behalf of the Health Industry Distributors Association (HIDA). HIDA is the national trade association of home care companies and medical products distribution firms. Created in 1902, HIDA represents more than 700 companies with approximately 2000 locations nationwide. HIDA members provide value-added services to virtually every hospital, physician office, nursing home, clinic, and other healthcare sites in the country, and to a growing number of home care patients. As the intermediary between medical products manufacturers and Medicare providers, HIDA Members are able to provide unique "ground level" recommendations to aid efforts to combat fraud and abuse in the Medicare Program.

As a professional trade association, HIDA wholeheartedly supports the rigorous enforcement of laws that ensure that Medicare pays reasonable reimbursement amounts for medically necessary items and services on behalf of Medicare beneficiaries. HIDA has long advocated the responsible administration of the Medicare program, and has repeatedly identified specific abusive or illegal practices occurring in the marketplace to assist the government's anti-fraud efforts. HIDA has also assisted in the development of additional targeted policies designed to aid the government in the administration of the Medicare program. This statement will focus on two such policies, Medicare supplier standards and nursing facility consolidated billing.

POLICY RECOMMENDATION NUMBER ONE: SUPPLIER STANDARDS

To help rid the industry of the few illegitimate players which jeopardize patient care, tarnish the industry, and unfairly distort the market for medical products, HIDA urges the Health Care Financing Administration and Congress to require that all Part B suppliers comply with standards that will assure Medicare beneficiaries receive a consistent quality of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) services. The following recommended supplier standards result from a fundamental belief that the current Medicare Supplier Standards (42 CFR 424.57 et. seq.) are simply insufficient. Importantly, it is not just the de minimus nature of the standards that is deficient, but also the process Medicare uses to determine whether a provider actually meets those standards. The following recommended standards therefore would inject some substantive meaning into the notion of being a Medicare provider of DMEPOS services.

These new standards are intended to build upon those currently administered through the Medicare National Supplier Clearinghouse (NSC). These standards would therefore apply to all firms that have or apply for a Medicare Part B supplier number in order to provide DMEPOS services and bill Medicare on behalf of beneficiaries. They reflect the consensus of a wide array industry leaders, national associations, state associations, HIDA Members, and other constituent interests.

If the NSC adopts the recommended standards and changes the process by which it determines whether a provider actually meets the standards, Medicare will realize an immediate benefit by ensuring that beneficiaries receive DMEPOS items and services only from legitimate firms. If an effective screening process is used, unscrupulous firms will never have an opportunity to engage in abusive behavior because they will never be able to bill the Medicare program on behalf of beneficiaries. Consequently, the standards will significantly contribute to reducing fraud and abuse in the Medicare program. For these reasons alone, Congress should require HCFA to adopt these Supplier Standards.

Organization of Standards:

1. Basic Business Standards would apply to all firms applying for a Medicare Part B Supplier/Provider number and any firm that currently has a Part B supplier number issued by the National Supplier Clearinghouse.
2. Standards for Providers of Respiratory Products would apply to all firms providing respiratory products and services to Medicare beneficiaries, and billing Part B for those products.
3. Standards for Providers of Home Infusion Therapy would apply to all providers of home infusion therapy, and billing Medicare Part B for these products.
4. Supplier Enrollment/Application Procedures and Verification describes a new process by which suppliers would receive a Medicare Part B supplier/provider number. The process includes verification of information submitted to Medicare, and an on-site visit to the firm.

Note on Terms:

Please note that the following terms are used interchangeably:

- patient, consumer, client
- supplier, provider

Basic Business Standards for Part B Suppliers:

The Basis Business Standards would apply to all providers/suppliers that apply for a Medicare Supplier number, and that are in the business of providing medically necessary durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) to Medicare beneficiaries either in their home or in a nursing facility.

Standard BB–1:

As Part of the Application Process, The Provider/Supplier Must Provide Basic Information, including:

1. Name

A. Registration/business license

B. D/B/A ("doing business as")

2. Tax identification number
3. Address verification
4. Proof of insurance

A. General product liability insurance

B. Professional liability insurance (if company has health care professionals as employee(s))

Standard BB–2:

Provider/supplier must comply with all federal, state and local regulatory requirements (e.g., licensure), and show proof of compliance when applicable.

Standard BB–3:

Provider/supplier must provide evidence of financial soundness. May be demonstrated in many different ways, for example by:
A. Bank references
B. Insurance property, liability
C. Trade credit references
D. Etc. (Dun & Bradstreet or other credit reports)

Standard BB–4:

Provider/supplier must have policies and procedures to cover basic scope of services for appropriate product lines.

Standard BB–5:

Provider/supplier must maintain all professional and business licenses and certifications, and show proof when applicable.

Standard BB–6:

Provider/supplier must have 24-hour a day, 7 day a week service availability for appropriate products and response to emergency situations.

Standard BB–7:

Provider/supplier routinely monitors the quality and appropriateness of services, equipment and supplies provided.

Standard BB–8:

Provider/supplier has a corporate compliance program.

Standard BB–9:

Provider/suppliers (owners and officers) shall not have been convicted of violations of Medicare and/or Medicaid rules and regulations.

Standard BB–10:

Provider/supplier attests that it is knowledgeable of the Medicare laws, regulations and policies pertaining to the billing of the applicable services, equipment and supplies provided.

Standard BB–11:

Provider/supplier has the capability (either directly or through contractual arrangements with other entities) to service customer locations, as evidenced by product inventory, distribution systems, and emergency backup systems.

Standard BB–12:

Provider/supplier provides its customers with educational resources relative to the products and services provided such as assistance with understanding Medicare regulations, provision of Medicare's toll free beneficiary help line, equipment inservices (if applicable), and product information.

Standard BB–13:

Provider/supplier has policies and procedure to document and resolve customer complaints and inquiries.

Standard BB–14:

Provider/supplier maintains regular business hours.

Standard BB–15:

Provider/supplier maintains a physical business location with its business name evidently displayed.

Standard BB–16:

Provider/supplier has procedures to document maintenance and repair programs for equipment as applicable.

Standard BB–17:

The patient/caregiver must be informed of the provider's compliance with all applicable HME Federal and State laws, regulations and Standards.

Standard BB–18:

The provider/supplier must assure that all the necessary and appropriate patient/caregiver education has been provided or arranged for with respect to the services, equipment, and supplies provided.

Standard BB–19:

The provider/supplier must provide patient/caregiver training in the safe and proper use of equipment, with a follow-up demonstration.

Standard BB–20:

The provider/supplier must inform, in general terms, the patient/caregiver of his/her financial responsibilities.

Standard BB–21:

The provider/supplier will assure that environmental considerations are addressed such that the continuing needs of the patient/caregiver are met in the safest possible manner.

Standard BB–22:

The provider/supplier only uses equipment and supplies that conform to generally accepted industry manufacturing standards.

Standard BB–23:

The provider must have a valid, current and accurate prescription for all equipment and supplies provided.

Standard BB–24:

The provider/supplier must notify the prescribing physician of apparent patient non-compliance.

Supplier Standards for Providers of Respiratory Products

These provider standards would apply to providers of respiratory products (in addition to the Basis Business Standards described above).

Standard Resp-1:

All patient/caregiver information must be kept in confidence (except when required to be released, for example, by JCAHO; and provider will first obtain client's permission).

Standard Resp-2:

Providers may only provide respiratory therapy equipment for which it is an authorized dealer.

Standard Resp-3:

The provider must perform and document scheduled in-home routine preventative maintenance of provider-owned (i.e., rental, loaner) equipment.

Standard Resp-4:

Either directly or through contracting with another entity, the provider must perform and document manufacturers' scheduled maintenance of provider-owned (i.e., rental, loaner) equipment.

Standard Resp-5:

Provider cleans, stores, and transports respiratory therapy equipment in accordance with the manufacturer's recommendations and all applicable Federal and local laws ad regulations.

Standard Resp-6:

The provider must have a valid, current and accurate prescription for all respiratory therapy equipment dispensed.

Standard Resp-7:

The provider must secure physician approval, either through a change in the prescription or through physician-approved protocols, before respiratory therapy equipment modality substitutions are made.

Standard Resp-8:

The provider only utilizes the services of personnel who are appropriately trained, qualified, and competent for their scope of services.

Standard Resp-9:

The provider utilizes services of health care professionals that adhere to all Federal and State laws, rules, and regulations.

Standard Resp-10:

Providers providing life supporting or life sustaining respiratory therapy equipment assume the responsibility to directly provide or arrange for the services of a respiratory therapist or equivalent.

Supplier Standards for Providers of Home Infusion Therapy

These provider standards would apply to providers of home infusion products (in addition to the Basis Business Standards described above).

Performance standards

Standard IV–1

Provider has competent staff:
A. Provider has trained, competent technical staff
B. Provider has access to qualified health professionals

Standard IV–2

Provider performs client assessments, which includes:
A. Appropriateness of therapy
B. Safety of home environment
C. Development of plan of care to establish product and service needs

Standard IV–3

Provider coordinates client care with other providers and practitioners:
A. Communication and interaction with other providers and practitioners
a. Patient assessment/service plan
b. Changes in patient's needs
c. Changes in patient's care regimen

Standard IV–4

Provider has a valid, current and accurate prescription for all products dispensed.

Standard IV–5

Provider schedules activities, including
A. Who does what and when

Standard IV–6

Provider performs patient/caregiver training which includes:
A. Indication for therapy
B. Administration of medications or formula
C. Operation and maintenance of pump
D. Inventory storage and management
E. Self-monitoring
F. Emergency response

Standard IV–7

Provider delivers, sets up and pickup equipment and supplies.

Standard IV–8

Provider performs ongoing monitoring and follow-up, including:
A. Assess response
B. Assess functioning of therapy delivery system
C. Assess product utilization, patient compliance
D. Assess continuing need for therapy (with others)
E. Equipment tracking, cleaning, maintenance and repair

Standard IV–9

Provider provides access to emergency response services
A. Services are available 24 hours a day, 365 days a year
B. Provider responds within reasonable time
C. Provider provides intervention as indicated.
a. Technical
b. Clinical provide instruction, visit or contact other provider

Information Management

Standard IV–10

Provider manages the following information related to the client:
A. Maintain clinical records
B. Patient satisfaction/grievances
C. Complications
D. Unscheduled deliveries and visits
E. Utilization data by service, by patient
F. Goals of therapy, patient needs

Application Process—For a Medicare Part B Supplier Number

The verification that a provider/supplier meets the Medicare supplier standards is vitally important to the provider/supplier industry, beneficiaries, and the Medicare Program to ensure that only viable providers/suppliers provide medically necessary DMEPOS items and services to Medicare beneficiaries.

HIDA recommends that non-governmental independent organizations verify that providers/suppliers comply with the Medicare supplier standards, both initially and on an ongoing basis. This recommendation is similar to the structure used world wide by the International Standards Organization (ISO). This process would be simple, minimize bureaucracy and paperwork, and most importantly, ensure the suppliers comply with the standards.

1. National Supplier Clearinghouse (NSC) would certify organizations that wish to verify suppliers meet the Medicare supplier standards.

2. These organizations would verify compliance based solely on the Medicare supplier standards. Verification would include:

- A complete review of the application,
- Written follow-up on questionable areas
- On-site visit to verify/check remaining questionable areas

3. There would be a time limit to complete the review process (no more than 90 days)

4. The provider/supplier pays the fee to the verification organization (a portion of which may go to the NSC to cover administrative costs).

5. There would be a three year cycle for renewal of Medicare supplier number to ensure ongoing compliance with the Medicare supplier standards. The fee would cover the three year cycle.

Note: HIDA supports a reasonable application fee to cover costs of verification. The recommendation is made with the understanding that these verification procedures will actually weed out the "bad actors;" non-legitimate companies would not be able to get a Medicare supplier number because of the rigorous screening of all applicants.

POLICY RECOMMENDATION NUMBER TWO: NURSING FACILITY CONSOLIDATED BILLING

The Administration's FY 1998 budget package contains a legislative proposal prohibiting any entity other than a nursing facility from billing Medicare for the medical supplies and services provided to nursing facility residents. This "consolidated billing proposal" does not distinguish between reimbursements for services covered by Medicare Part A vs. Part B.

HIDA supports consolidated billing for nursing facility residents who are covered by Medicare Part A. We understand that Part A consolidated billing is needed to gather the information that the Health Care Financing Administration (HCFA) needs to develop the nursing facility prospective payment system. However, HIDA believes that nursing facilities should retain their ability to use outside suppliers of medically necessary Part B services when the resident is not covered under the 100-day Part A stay. This choice is more efficient and economical for many nursing facilities.

Outside suppliers provide nursing facilities with a number of services that promote positive health outcomes. Value-added services provided by medical suppliers including storage, inventory management, clinical services (e.g., respiratory therapy,

nutritional assessments, support for wound care protocols), billing and collection, and outcomes support. Many nursing facilities do not have the administrative staffing, physical space, or other resources to ensure that adequate quantities of the appropriate products are available to meet each patient's needs, especially since some patients require products on an emergency basis or have frequently changing needs. As a result, beneficiaries could be denied access to the wide range of high quality, medically necessary products that are currently available.

The Health Industry Distributors Association opposes consolidated billing for nursing facility residents who are not covered by Medicare Part A because:

Concerns Relating To Fraudulent Billing Are Not Applicable After The 100 Day Part A Stay: It is argued that consolidated billing is needed to eliminate the opportunity for fraudulent "double billing" of Medicare Part A and Part B. These concerns can be addressed through Part A consolidated billing—simultaneous billing of Part A and Part B is not feasible for residents who are not covered by Part A. In addition, the new Durable Medical Equipment Regional Carriers (DMERCs) have instituted tight controls over the Part B benefit. With full time Medical Directors developing and implementing strict guidelines defining medical necessity and utilization of medical supplies, the DMERCs have been highly effective in combating fraudulent billing practices. Therefore, irregularities in the Part B billings of outside suppliers providing services to nursing facility residents are readily apparent under the current system.

Consolidated Billing Would Impose New Cost Burdens On Nursing Facilities: By requiring fully consolidated billing, even when beneficiaries are not under a Part A stay, many nursing facilities that previously utilized outside suppliers to provide their residents with medically necessary supplies and services would be required to provide these services themselves, to directly bill for these supplies and services, and to assume other responsibilities that are currently fulfilled by outside suppliers. These responsibilities and services would add significant costs to a nursing facility. Importantly, current law allows a nursing facility to act as a Part B supplier; presumably those facilities who choose to do so now would continue this practice in the future if it is their best option.

Consolidated Billing Is, At Best, Budget Neutral: The proposed legislative prohibition against the use of outside suppliers is considered revenue neutral, as it is characterized by the Congressional Budget Office as a billing requirement. In reality, fully consolidated billing would likely increase costs to the health care system, since the supplier community provides valuable billing expertise, inventory control, staff education and clinical services which the facilities will need to replace.

Consolidated Billing Is Not Necessary For Prospective Payment: It is argued that consolidated billing is necessary to collect the data needed to construct a prospective payment system for nursing facilities. However, there is no prospective payment proposal for the Part B benefit, which will continue to exist unless Congress specifically eliminates it.

Conclusion

HIDA appreciates the opportunity to submit these recommendations to the Subcommittee. We urge Congress and HCFA to strengthen the Medicare program by implementing rigorous supplier standards and requiring nursing facility consolidated billing during the 100-day Part A benefit. These two recommendations will aid in the ongoing effort to combat Medicare fraud and abuse while promoting the provision of consistent, high quality services to Medicare beneficiaries.

Contact: Cara C. Bachenheimer and Erin H. Bush

Statement of Dwight S. Cenac, Chairman of the Board, Home Care Association of America (HCAA), Jacksonville, Florida

Mr. Chairman and members of the committee, on behalf of Home Care Association of America (HCAA), I am honored to share our views concerning the critical issues related to Medicare policies for post-acute services, especially home health care. HCAA represents over 400 freestanding home health agencies across the United States. Also, I want to express that HCAA is in favor of Prospective Payment for Home Health Care as long as it pays for what services are provided, not for services NOT PROVIDED.

This submittal is divided into five sections:

I. Guarantee Patient Choice
II. Implement a Per-Visit PPS Plan with a National Cap
III. Ensure No Shift Part A to Part B
IV. Re-Evaluate Operation Restore Trust (ORT)
V. Create Proper Regulations to Control HMOs

ISSUE I: GUARANTEE PATIENT CHOICE

HCAA's Position:

The most critical issue (according to a recent survey of 2,400 freestanding home health agency owners) is the rampant denial of patient choice by hospitals who are "downstreaming" patients into their hospital-owned home health agency for profit. We ask Congress to require HCFA to enforce existing regulations (42 CFR 424.22) prohibiting the improper downstreaming of hospital self-referrals (for profit) from physicians they compensate. We also urge Congress to instruct HCFA to reinstitute the two "Hoyer Letters" pertaining to enforcement of 42 CFR 424.22.

42 CFR 424.22 is an "existing" regulation issued to protect the patient's right to choose (which HCFA is deliberately refusing to enforce). It is imperative that the patient is allowed, without coercion or manipulation from hospital discharge staff, the freedom to choose his/her post-acute provider, and that choice must be honored by the hospital and enforced by HCFA. We have heard from freestanding home health agency owners across the country that patients they have been treating, when readmitted into the hospital, were subsequently, and wrongfully, downstreamed to the HOSPITAL's OWNED HOME HEALTH AGENCY for profit.

Refusal to protect patient choice is not the only recent attempt by HCFA not to enforce appropriate rules against big business. In the February 1997 AARP Bulletin, Don McLeod states, " The Clinton administration strongly denies charges leveled by some that it's getting ready to water down safety and care standards for nursing homes." In the same fashion, HCFA is "watering down" regulations pertaining to downstreaming hospital self-referrals from physicians they compensate.

HCAA has always believed that 42 CFR 424.22, as promulgated by Sections 1814 and 1835 of the Social Security Act (see background below), is crystal clear. One top HCFA official issued two letters, (the "Hoyer Letters") correctly stating that hospitals were in violation of 42 CFR 424.22 if they self-referred, for profit, but HCFA withdrew these letters (Federal Register, November 29, 1996, Vol. 61, No.231) and has squashed all attempts to enforce the law. HCAA believes this act by HCFA is in violation of the Administrative Procedures Act (which requires a period for review and comment from the public and industry, before it abolishes an existing rule promulgated by law). HCFA and self-serving hospital opponents of this long-standing regulation, including the American Hospital Association (AHA), say that new health care systems which have developed over the past several years have made 42 CFR 424.22 outdated and obsolete (since when is protecting the patient's right to choose obsolete?). The AHA has vigorously and successfully lobbied Secretary Shalala in declaring a "moratorium" on enforcing this regulation until Stark II legislation is finalized (as evidence in the November 29, 1996 Federal Register stating HCFA's withdrawal of the "Hoyer Letters"). HCAA believes that by retreating on 42 CFR 424.22, improper hospital self-referrals, made for profit, will drive up costs, eliminate competition and deny patient choice.

Background:

The Social Security Act in Sections 1814 and 1835 states:

"With respect to the physician certification ... for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no

later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, ..."

From the Social Security Act (see above), 42 CFR 424.22 was written.

42 CFR 424.22 entitled, "Requirements for home health services" states:

(d) Limitations on the performance of certification and plan of treatment functions.—(1) Basic rule. Beginning November 26, 1982, and except as provided in paragraph (e) of this section, need for home health services to be provided by an HHA may not be certified or recertified, and a plan of treatment may not be established and reviewed by any physician who has a significant ownership interest in, or a significant financial or contractual relationship with, that HHA.

42 CFR 424.22 section (3) clearly states:

Significant financial or contractual relationship. Beginning November 26, 1982, a physician is considered to have a significant financial or contractual relationship with an HHA if he or she—(i) Receives any compensation as an officer or director of the HHA; or (ii) has direct or indirect business transactions with the HHA that, in any fiscal year, amount to more that $25,000 or 5 percent of the agency's total operating expenses, whichever is less. Business transactions means ... salaried employment.

Issue II: Implement a Per-Visit PPS Plan With a National Cap

HCAA's Position:

We urge Congress to accept a "Per-Visit" Prospective Payment System (PPS) with a national cap. We urge Congress to reject any "Per-Episode" Prospective Payment System (PPS) Plan, including the falsely named "Unified PPS-Plan" (HCAA, the American Federation of Home Health Agencies and over 95 percent of all freestanding agencies who responded to HCAA's January 1997 survey reject this "Unified PPS-Plan"). A Per-Episode payment mirrors the flawed HMO payment method by offering incentives to deny needed care. Instead, we ask Congress to consider the merits of Per-Visit PPS which pays for care given. We also ask Congress to urge HCFA to work with HCAA to design an alternative Per-Visit Plan so that Congress will be afforded two options to choose from (Per-Visit or Per-Episode) versus HCFA's current plan which is to give Congress only one option (Per-Episode).

Background:

In a recent survey of 2,400 freestanding home health agencies, 95.55 percent all those responding preferred HCAA's Per-Visit prospective PPS Plan for home health versus the Per Episode PPS Plan. HCAAs Per-Visit Plan (with a national cap on expenditures) is the only plan that will ensure that patient care is the first priority, that the government is receiving services for the money it pays for, and that there is a guarantee that costs will be contained. If Congress adopts a flawed Per-Episode PPS Plan, the government will be paying a lump-sum per episode, and patient care will be sacrificed in favor of profit. In fact, the government will be paying for services NOT rendered and there are no real guarantees that costs will be contained.

Studies by HCFA have proven that HMOs have been vastly overpaid. The same results will happen in the home health industry if Per-Episode PPS is implemented.

To prevent overutilization, HCAA endorses a Per-Visit PPS Plan coupled with a national cap for home care expenditures, thereby guaranteeing that cost increases will be controlled, and realizing a savings for the Medicare program. Let's not repeat the tragic premature implementation of PPS in home care that occurred in 1983 for hospitals, resulting in today's 20 percent increase in care, compared to the 400 percent increase in cost of that care.

Issue III: Ensure no Shift from Part A to Part B

We urge Congress to reject the proposal to shift home health spending from Medicare's Part A Trust Fund to Part B.

Background:

HCAA strongly believes that patient care will be seriously jeopardized if Congress allows a shift of payments from Part A to Part B, pertaining to home health services.

The motive to shift home health payments from Part A to Part B clearly is "smoke and mirrors." This shift will give the false impression that the Part A Trust Fund is becoming solvent. Moreover, by shifting home health payments over to Part B, the threat of a "sick-tax" would be greater due to the co-pay provision in Part B.

Assurances by the Administration that home health would not be exposed to a co-pay are just a diversionary tactic to deceive Congress in approving this "shell game."

Furthermore, shifting home care payments from Part A to Part B would make home care services vulnerable to being bundled with hospital DRGs. Bundling would then give hospitals a virtual monopoly on the health care market. Bundling will encourage hospitals to "self-refer" to their hospital-owned, post-acute care facilities (i.e. home health agencies, skilled nursing facilities, etc.). Freestanding home health agencies would not have a level playing field to compete for home care patients. Hospitals would be the gate-keeper for Medicare disbursements, and it is highly unlikely that they would allow patients the freedom to choose a post-acute care health care provider which does not benefit the hospital financially.

In addition, home health care is far less costly than hospital or nursing home care and should not be discouraged, as it would be if shifting Medicare payments from Part A to Part B were allowed.

ISSUE IV: RE-EVALUATE OPERATION RESTORE TRUST (ORT)

We urge Congress to call for an investigation into HCFA's improprieties under the guise of Operation Restore Trust (ORT).

1. We believe that HCFA is using Operation Restore Trust (ORT) to circumvent due process of law of freestanding home health agencies. With the enormous influx of funds from the recent Kennedy-Kassebaum law, HCFA now has virtually unlimited resources to force ethical freestanding home health agencies out of business. We ask the Congress to ensure ORT is fair and evenhanded.

2. We urge the Congress to hold hearings on the tactics, results and scope of ORT. Freestanding home health agency owners who have been harassed by ORT surveyors must be allowed to testify before Congress. In addition, Judy Berek, Special Advisor to the HCFA Administrator, must be asked direct questions about the tactics her surveyors are using to force freestanding agencies out of business.

3. We ask the Congress to demand that HCFA honor the favorable (and correct decision) in the CSM case in California (see background, following).

4. We ask the Congress to urge HCFA to expand Operation Restore Trust to hospital-owned agencies and large chains.

5. We ask the Congress to demand that HCFA reject ORT's proposed sampling method. This "sampling" method being considered by HCFA ORT staffers will give agencies a "take it or leave it" scenario that is nothing short of blackmail. HCFA's idea is that they will choose certain "high utilization claims," heavily scrutinize those, and then project their denials out to all claims for two months. If the agency doesn't contest their denials, all is well but if they do contest, then the entire year will be subject to denials.

6. We also request that a Providers' Bill of Rights be developed, with input from HCAA and AFHHA. This Bill of Rights, similar to that found in the nursing home industry, and proposed by AFHHA, would protect home health agencies from overzealous and unethical ORT surveyors and offer due process of law without fear of government retaliation.

Background:

Under the guise of rooting out fraud and abuse in the Medicare system, the Health Care Financing Administration is using Operation Restore Trust to drive freestanding home health agencies out of business. To prove this horrendous, unbridled government abuse of power under ORT, we submit the case of CSM Home Health Services, Inc. (CSM).

CSM, owned by Mariano Velez, is a 10-year-old Los Angeles agency, that passed survey every year-but after an ORT survey, CSM has spent more than $100,000 on legal and consulting services to fight an improper ORT Medicare decertification of their business.

CSM initially sought injunctive relief against HCFA's decertification plan. The presiding judge over the CSM injunctive relief case, the Honorable John G. Davies (Case No. CV 96–4651–JGD), dated Friday, July 19, 1996, United States District Court-Central District of California, could find no legal grounds (this is precisely why Congress' intervention is needed) to grant CSM continued injunctive relief, although he definitely wanted to. Judge Davies said of the ORT process, "I think the surveyors—I think CSM Home Services has a case. The evidence that is before me that I have perused, read, considered, leads me to those conclusions. The Surveyors, I had the impression, were not reticent to wear their power on their cuff and to manifest it and exercise it in ways that are undesirable in today's society. The bureaucracy overreacted once again. That is my view of this case. But, what relief can I give you?"

With no continued injunctive relief, and being stripped of its Medicare provider number, CSM's case was then referred to Steven T. Kessel, Administrative Law Judge. Judge Kessel heard an intensive week of formal testimony by both CSM and HCFA staffers. In his decision dated October 11, 1996, in the case of CSM Home Health Services, Inc., Petitioner versus the Health Care Financing Administration, Judge Kessel states, "I decide that the Health Care Financing Administration (HCFA) incorrectly determined to terminate the participation in the Medicare program of Petitioner, CSM Home Health Services, Inc. In this case, HCFA asserted that Petitioner failed to comply with four conditions of participation in Medicare. I find that the preponderance of the evidence is that Petitioner complied with all four of these conditions."

What is even more alarming is what Judge Kessel states later in his decision, "In many instances, HCFA rests its allegations on characterizations of facts which are not supported by the evidence. In some instances, HCFA asserts that nurses employed by Petitioner failed to discharge specific directives in patients' plan of care when, in fact, the record proves that they did precisely what they were ordered to do. HCFA asserts also that Petitioner failed to conduct a required program evaluation despite overwhelming evidence that Petitioner performed the evaluation."

HCAA staff attended Judge Kessel's week-long hearing and was shocked at the false and misleading testimony offered by HCFA's ORT "experts." Anticipating a favorable ruling by Judge Kessel, HCAA requested HCFA Administrator Vladeck, in a personal meeting on September 20, 1996, to honor the predicted forthcoming favorable decision. HCFA chose to ignore HCAA's request, has appealed Judge Kessel's ruling (thereby keeping CSM out of business), and continues its improper attack on CSM.

CSM owner Mariano Velez, in a January 31, 1997 letter to HCAA Chairman Dwight Cenac, disparagingly reflects on the apparent lack of justice that allows HCFA to go unchecked on its unwarranted attack against his agency, "These past few months have been terrible for me, and I fear the burden has gotten the best of me, causing the worst case of depression that I have encountered, so much so that I felt a deep sense of fatigue, a loss of energy, as well as spirit, to continue living from day to day. I share this with you because what happened to me should not happen to anyone else. ... As you probably know already, HCFA has filed their appeal to reverse the ALJ (Judge Kessel's) ruling on CSM's case. And because of our outstanding debt to our lawyers, we have not been able to reply to HCFA's appeal. I am afraid all is lost—for the industry as well—if the ruling is reversed."

Congress needs to demand an investigation into the abuses of HCFA/ORT fraud and abuse practices and into the CSM case. Ethical small businesses, whose sole purpose is to serve their community (such as CSM) should not be a victim of HCFA/ORT abuse. Congress should demand CSM be the victor, not the victim.

HCAA is not alone in its concerns and observations regarding the need to oversee such ORT abuses. July 1996 testimony given by Susan Bailis, of the American Health Care Association (AHCA), has stated that the House Ways and Means Subcommittee on Health should "carefully monitor the implementation of the 1995 Survey, Certification and Enforcement rules to ensure they are cost-effective, and are not abused by over-zealous inspectors and are enforced fairly and evenly." Do not be deceived by reports from HCFA that ORT is taking in $10 for every $1 spent. The Congress must ask HCFA the following questions:

1. How many freestanding agencies have been targeted by ORT, and how are they targeted?
2. How many agencies targeted by ORT are MINORITY-OWNED?
3. How many hospital-owned agencies have been targeted by ORT?
4. How many agencies (like CSM) have been de-certified before their case was judicially decided?
5. How may big businesses (hospitals, etc) have been de-certified by ORT?

ORT, under the direction of Judy Berek, Special Advisor to HCFA Administrator Bruce Vladeck, is using the financial resources of the United States government to drive honest, ethical and in some cases, minority home health agency owners out of business without cause. HCFA wrongly believes that freestanding proprietary home health agencies are the cause of increased spending in the home health industry when, in fact, it is hospital-based/owned home health agencies that are the cause of runaway spending.

In an overview of "National Health Expenditures for 1995," HCFA's Office of the Actuary concludes that "payments to hospital-based home health agencies ... have been growing faster than those for freestanding agencies." Between 1994 and 1995, spending on hospital-based home care services rose at a rate of 22.1 percent, as compared to a rate of spending growth of 8.6 percent for freestanding home care agencies.

If HCFA is sincere about rooting out fraud and abuse, why predominantly target freestanding agencies when costs of hospital-based/owned agencies far exceed costs of freestanding home care agencies.

HCAA applauds efforts by the federal government to root out fraud and abuse and welcomes "even-handed" audits to do so. But, HCFA has been adamant about NOT ALLOWING cooperation between the industry and the government, pertaining to ORT. HCAA calls for an ongoing cooperative working relationship with HCFA to stop fraud and abuse and an end to improper ORT de-certification tactics.

ISSUE V: CREATE PROPER REGULATIONS TO CONTROL HMOS

HCAA's Position: a U.S. Senator from the State of

Stop HMOs from overbilling Medicare billion $

HCAA applauds the President for proposing to save $20 Billion over five years by reducing payments to HMOs. Congress should embrace this proposal. HCAA urges Congress to insist that the decrease in HMO payments not be delayed to the year 2000, as requested by Secretary Shalala, but be implemented immediately to begin saving our Medicare program from bankruptcy.

In fact, HCAA believes we can do more. HCAA recommends legislation to save the desired six percent (over $16 billion) in Medicare dollars annually, by requiring HMO Medicare reimbursements to incorporate a "case-mix" capitation adjustment. Currently, HMOs are paid an average of $4,500 per Medicare beneficiary, which was falsely computed based upon the naive assumption that HMOs would enroll a case-mix of both healthy and sick Medicare beneficiaries. Because it has now been proven that HMOs seem to target the healthy elderly for enrollment, and because these healthy enrollees cost Medicare less than $500 a year (Consumers' Research, 7/95), HMOs are costing (not saving) Medicare the billions of dollars that, alone, would keep the program solvent. For example, a "case-mix" capitation adjustment factor (i.e., payment of only $500 for healthy elderly enrollees, versus the current $4,500), would guarantee that HMOs would be paid only what it costs to provide quality care, plus a fair reimbursement for administration and profit. On Nov. 11, 1995, the GAO delivered its fourth HMO report to Congress with this statement, fully supporting HCAA's conclusion: "HMO Rate-Setting Methodology Thwarts Medicare's Efforts to Realize Savings." In fact, an NBC News expose documented that 90 percent of all Medicare beneficiaries cost an average of only $1,900 per year under traditional Medicare. HMOs currently overcharge Medicare $16 BILLION annually.

In addition, we urge Congress to move forward on hearings pertaining to managed care (i.e. managed denial of care) that President Clinton called for last year.

Statement of National Association for the Support of Long Term Care

Mr. Chairman,

As members of The National Association for the Support of Long Term Care (NASL), we appreciate the opportunity to submit a statement for inclusion in the record of the March 4, 1997 hearing entitled "Home Health Care and SNF and Other Post Acute Care Payment Policies." This statement will focus primarily on support for reforms in payment for skilled nursing facility services that will adequately pay for the care and treatment of seniors.

NASL is the only national organization that concentrates exclusively on legislation and regulatory matters regarding the provision of professional medical services and supplies to beneficiaries in post-acute care settings. NASL supports the option that the skilled nursing facility has to contract for medical services when they are needed. The authority to provide services "under agreement" or "under arrangement" gets Medicare savings as services are purchased only when a patient needs the medical care.

In testimony which we presented to this Committee in 1996, we emphasized our support:

- for transitioning to a prospective payment system under Part A for skilled nursing services,
- for reforms which require billing Part A for Part A services, and,
- for eliminating artificial legal barriers to services for nursing home residents, such as transfer agreements and three-day stay requirements.

NASL has recently endorsed a nine point plan for implementing realistic skilled nursing facility payment reforms. The following is an overview of the approach which we are recommending to Congress and the Administration.

We urge the Congress and the Department of Health and Human Services to pursue payment reforms which achieve the following goals:

- enhance quality and improve beneficiary services,
- assure beneficiary access to appropriate services,
- improve accountability,
- reduce the rate of growth of Medicare SNF expenditures,
- protect against inappropriate utilization, and,
- institute reforms that can be implemented.

Applying these principles, NASL recommends the following:

#1: Transition to a SNF Part A Prospective Payment System:

NASL supports a transition to a Part A SNF prospective payment system. We urge the legislation be explicit in directing the Secretary to design the program to (a) reflect legitimate differences in cost differences between patients, (b) encourage appropriate access to medically necessary services, (c) encourage the provision of high quality medical care, (d) provide incentives for improving the efficiency in delivering services, and (e) base decisions on timely, accurate and relevant data.

The disruption of beneficiary services can be minimized through a realistic implementation of a prospective payment system. Steps can be taken in the coming year to transition existing routine services to a prospective system using an appropriate patient acuity classification system. It will take additional time to develop appropriate classification measures for ancillary services, thus, the inclusion of these medical services should be phased in separately from the schedule for basic nursing services. Likewise, payment for capital should also be phased in when appropriate measures are defined. Better data coupled with a transition from facility specific to national rates should be included in the PPS reform. Implementing these steps over a five year period is rational policy.

#2: Inclusion and Appropriate Classification of Part A Services:

The standard package of SNF services varies widely based upon patient needs, program size, and location. Though skilled nursing facilities offer a relatively defined set of routine services, most also offer a menu of diverse ancillary medical services. Facilities with a number of high acuity patients have high ancillary costs because these patients are in greater need of medical care services; facilities that focus on basic nursing services have relatively low ancillary costs.

NASL supports billing for standard SNF Part A covered services through the skilled nursing facility. Such an approach ensures an accurate accounting of all costs during that stay when in the design of the prospective payment system. It fur-

ther ensures beneficiaries will receive a single bill for such services during the Part A stay. Senior citizens should receive routine and ancillary services when they need them. Implementation will require a recalculation of base year costs and an adjustment in the market basket to reflect the additional Part A costs that are currently billed to Part B.

We do not support the consolidation of payment for Part B services that follow the Part A stay. Consolidation should not be taken to this extreme. It will penalize facilities that have been innovative in meeting community needs. We urge policymakers to distinguish between those services which are standard within SNF delivery and those occasional or atypical covered services which some SNFs provide. Few SNFs specialize in treating burn patients, AIDS patients, pediatric patients, ventilator dependent patients, spinal cord and head injured patients—but some do. These innovative programs will not be economically sustainable if program costs are averaged or consolidated into the payment across all facilities.

#3: Simplified Rules for Low-Volume Facilities:

Reforms need to balance the twin goals of community availability and service efficiency. Program data underscores that fewer than a third of participating facilities account for 90% of Medicare SNF days and Part A costs. A complex SNF prospective payment requirement should not be imposed on facilities with an average daily census of 10 or fewer Medicare patients. Complexity will drive many low-volume providers out of Medicare thereby leaving beneficiaries unable to secure services. Rural and medically underserved communities will be penalized. Congress should extend and update the existing provisions for low-volume facilities and exempt them from the new PPS system.

#4: Implement Measures for Clinical Effectiveness and Delivery Outcomes:

There is a need to re-establish patient care as a priority. Post acute providers are subjected to reams of rules and regulations, scores of surveyors and overseers, and mountains of paperwork. Has anyone ever asked does it make a difference in patient caring?

Hearings before this Committee last Fall discussed innovative approaches for care management that are currently used in the private sector. These tools should be put into place for public sector programs. There is an important shifting of managerial focus from input measures to output measures; i.e., measuring whether services are clinically effective and improve delivery outcomes, Medicare, the largest purchaser of health services, is behind in developing similar care standards.

A decade ago, the Congress pressed the Secretary to develop and implement standardized patient assessment tools. Today, that information is the basic building block for care planning. NASL believes that Congress should direct the Secretary to develop and test measures for clinical outcomes that improve patient care.

#5: Controls on Inappropriate Utilization:

Program abuses infringe upon the integrity of all providers and suppliers. Most caregivers are diligent, conscientious and professional. Some are not. Enforcement of clear and concise rules is essential to remove from our system those providers who intentionally commit fraud in the health care system.

The current system of oversight is a dismal failure. Rules are vague, interpretations varied and personal preferences have replaced professional judgments. Increasingly, we are witnessing carriers and intermediaries setting new rules. They redefine coverage and payment without notice and impose new standards that restrict the coverage of seniors. Authorizing the Secretary to work with provider, suppliers, and professionals in developing statistically verifiable normative standards for utilization, and linking those standards to measures of clinical effectiveness and delivery outcomes will both overcome the inadequacies of the current non-system and improve data on episodes of care. We recommend that Congress restrict the authority for determinations on inherent reasonableness to HCFA that will reduce the potential of unfair and unjust actions by intermediaries and carriers and replace it with a process that is fair.

#6: Improved Accountability for Part B Services and Supplies:

SNF volume of admissions and discharges fluctuates, patient needs vary, and there are significant differences between Part A lengths of stay and total length of stay in a facility. Under current nursing home requirements, facilities have the obligations to oversee the provision of all services to all residents, but payment rules

permit facilities to secure services through in-house programs, "under arrangement," or "under agreement." Most SNFs received their specialty medical services through "under arrangement" and "under agreement" contracts.

Concerns have been raised as to whether there is adequate oversight of "under agreement" contracts to verify the care and its costs. These concerns can be realistically addressed by requiring facility/supplier contracts for Part B delivered services, and requiring access to contractor records. Such an approach does not disrupt service options for the facility and meets the oversight needs. NASL members do support increased accountability by all providers in ensuring services are provided that are medically necessary. Nursing home providers should work with providers or suppliers of services in ensuring services are provided and the documentation is maintained. Physicians should also be required to provide the adequate documentation, including diagnosis when required, to ensure the service is medically necessary. This important collaboration among providers and suppliers should work to ensure that nursing home patients receive the most appropriate medical care.

The members of NASL oppose the consolidation of billing for Part B services through the SNF except for those standard SNF services delivered during the Part A stay.

The reasons that NASL opposes consolidated billing for Part B services are:

1. The additional administrative burden and fiscal impact;
2. No documentation of unresolved problems with current billing practices;
3. Loss of access to small rural facilities; and
4. Loss of additional consulting and "value added" services to facilities, based on dropping Part B services.

#7: Meaningful Consultation with Affected Parties:

Realistic reforms will require a continuing dialogue among the affected parties. Providers, suppliers and beneficiaries are the experts and they must have a meaningful voice in designing and implementing reforms. A technical advisory panel, separate and distinct from those organized to evaluate hospital and physician payment reforms, must be empowered and assigned specific consultation activities.

#8: Streamlining of Program Requirements:

The complexity of current law stifles innovation and program efficiencies. Removing outdated requirements, such as the "transfer agreement" that require facilities to contract with hospitals for the provision of respiratory and medical diagnostic services, would improve market competition and reduce costs. We also support the elimination of the three-day stay requirement as academic studies and private sector approaches question the necessity for mandating a three-day prior hospitalization requirement for certain medical diagnoses.

#9: Support for Future Payment Changes:

NASL strongly supports the authorization of expanded data collection and research activities. Timely, accurate and relevant data is needed to support proposed changes and to plan for future program changes. Attention must be given to developing a realistic SNF market basket which expands the current nursing based index to account for a broader array of included SNF services. Measures of patient acuity must be perfected. Actions must be taken to better define "care episodes." Linkages across post-acute services must be better examined and defined. The Secretary should be encouraged to explore alternative post-acute payment approaches and to bring her plans back to the Congress for oversight and approval. However, we oppose any effort to bundle the post acute care payment into the hospital DRG. Finally, we applaud previous Congressional rejection of granting HCFA competitive bidding authority. These proposals will lead to discounted, low-quality health care services.

Summary:

The members of NASL support reasonable payment reform that encourages greater efficiency in providing services to seniors in the skilled nursing home. Seniors need appropriate services. We need clear and concise rules. We are ready to assist you with these issues so that constructive Medicare reforms can occur this Congress.

Statement of National Subacute Care Association, Sanford J. Hill, Executive Director, Bethesda, Maryland

MEDICARE SKILLED NURSING FACILITY PAYMENT AND REIMBURSEMENT

Medicare Savings and Reform

The Clinton Administration and the United States Congress are presented with a unique opportunity to reduce the growth of Medicare expenditures by adopting market-oriented efficiencies that are attainable through a prospective payment system based on episodes of patient treatment—without sacrificing access to and quality of healthcare.

A Transitional System Towards an Episodic PPS

While NSCA strongly endorses an episodic, site-neutral prospective payment system (PPS) for skilled nursing facility (SNF) care, we recognize that the Administration's pending proposal for a PPS can offer a necessary transition to a soundly-developed episodic based system. NSCA urges implementation of such a transition payment system for SNF care beginning in FY 99 (October 1, 1998). Our transitional payment proposal is attached to this document, and would call for payments for routine and ancillary costs for each provider to be capped on a combined basis using the filed 1996 cost reports with exceptions.

Medical Incentives and Reducing Medicare Growth

NSCA urgently emphasizes that an episodic-based PPS focused on the patient's medical condition and severity of illness and ancillary requirements, rather than on per diem and/or provider licensure type, would incentivize providers to place patients in the most medically-appropriate setting without distorting that decision with payment incentives. An episodic system removes incentive for a provider to keep a patient longer than necessary and it does NOT limit patient access to the specific type of care they need. An episodic PPS can effect genuine, documented reductions in the rate of growth of Medicare and it can ensure patient access to and receipt of quality health care.

New Patient Case-Mix Information

Important new patient case-mix data is emerging that supports the development of a PPS based upon episodes of care. Until this patient case-mix data is totally developed, however, NSCA urges the Congress and the Administration to support the implementation of a transitional payment system, such as that we have proposed and which other healthcare experts and organizations, such as the American Health Care Association (AHCA) have similarly endorsed.

A new patient case-mix patient classification and severity-indexed system applied to SNF patients will quantify important cost, resource allocations, and clinical outcomes emerging from subacute care. The further collection, analysis, and refinement of this new patient data will augment the integrity and effectiveness of a fully functioning episodic based PPS that Health Care Financing Administration (HCFA) can implement with confidence that payment and reimbursement of healthcare costs will be accurately and honestly made, without sacrificing access and quality of such care.

Administration Proposals

NSCA supports the Administration proposal for an across the board reduction in the "market-basket" baseline, and we cautiously support consolidated billing for all SNF services to Part A patients while awaiting the outcome of internal industry and government discussions concerning consolidated billing to Medicare Part B patients. We urge the HCFA to fully explore with Congress the details and policy consequences involved in the actual operation of such consolidated billing, and we encourage a thorough review of these issues with providers before the final legislative language is drafted.

Fees and Accreditations

NSCA opposes the imposition of new "user fees" for initial certifications under Medicare proposed for new facilities and we continue to support the use of HCFA-regulated professional accreditation organizations, such as JCAHO, for SNF survey and certification. JCAHO is currently used for hospitals which are more complex than nursing facilities/units. Additionally, the process uses a continuous quality improvement approach which is a more effective way to produce on-going, positive

change in health care delivery than the current survey process being used. JCAHO requires the use of a certified outcome measurement and management system, and is more stringent in other areas such as credentialling, plant safety and equipment maintenance. Utilizing a professional accreditation organization would save as much as $110 million per year.

Congressional Oversight

NSCA believes it is in the public interest for HCFA to collect and refine data necessary for the development of an integrated, post-acute care payment system. Specifically, we endorse the collection of data that would support an episodic PPS preceded by a transitional payment system. We oppose granting the authority for the Secretary to implement any such system without Congressional oversight or approval.

Medicare Reform Without Sacrifice of Healthcare Access and Quality

Subacute care is intended to be quality, less costly rehabilitative and transitional care, achieving cost savings by providing such care in less expensive non-acute settings. The Medicare program can benefit by an episodic PPS system which recalibrates the most common post-acute care Diagnostic Regional Groupings (DRGs). Reduction in patient length-of-stays will garner saving for Medicare as well as for hospitals, and the availability of post-acute care will allow those efficiencies to be realized.

NSCA Position Summary

In summary, NSCA offers its full support for legislative and regulatory initiatives that will create a Transitional SNF Payment and Reimbursement System that will evolve into an episodic, site-neutral Prospective Payment System that assures access to quality healthcare for all Americans and is based upon the emerging patient case-mix information so important to treating individuals on the basis of their verified medical condition rather than payment incentives.

TRANSITIONAL PAYMENT PROPOSALS

NSCA proposes the following conceptual proposals with the understanding that the dates and dollar amounts will be adjusted based on Congressional response and Congressional Budget Office estimates.

Establishment of a SNF Prospective Payment System

1. Require the Secretary of the Department of Health and Human Services to develop an episodic based prospective payment system for all skilled nursing facilities (freestanding and hospital-based) by 10/1/99. The Secretary shall establish performance based incentives for meeting discharge-to-home, length of stay and functional improvement targets. The system will be acuity based with multiple case mix categories to recognize the various levels of intensity of nursing and therapy sessions. In developing the PPS, the Secretary is to use the 1996 cost reports. This system is designed to create savings over the budget period.

Transitional Savings Until SNF PPS

2. Interim Rate Combining Routine and Non-Routine Costs—Until the prospective payment system for SNFs is implemented, an interim prospective system would be implemented beginning with fiscal year 1998. This system would call for payments for routine and ancillary costs for each provider to be capped on a combined basis using the filed 1996 cost reports with exceptions. The method for calculating the combined rate shall be a composite rate including routine services (SNF-participating cost divided by SNF-participating patient days) plus ancillary services, (Medicare ancillary cost divided by Medicare patient days) and including allowable exceptions. This rate will be the payment for each Medicare patient day. This composite rate for routing and ancillary costs would be updated by the hospital market basket minus some percentage in FY 1998 and by the full market basket from FY 1999–FY 2002 (if no permanent prospective payment system has been developed).

3. Maintain Exceptions—All skilled nursing providers will be included in the new prospective payment system on its implementation. Until that time new providers and providers who begin to develop atypical services in existing facilities must demonstrate to the intermediary and HCFA that atypical services were provided and the rate shall be adjusted to reflect the cost of providing atypical services. For providers just emerging from their new provider exemption period, for periods starting FY 1997, the provider must demonstrate to the intermediary and HCFA that atypical services were provided and the rate shall be adjusted to reflect the cost of providing

atypical services. For providers with exceptions granted for the cost reporting periods ending FY 1995, 1996 and 1997, their rate for FY 1998 shall be adjusted based on their 1997 approved exception.

4. Reduce Exemption Period—Reduce the new provider SNF exemption period by one year so that an exemption granted expires at the end of the provider's first cost reporting period beginning at least one year after the provider accepts its first patient. New providers would file for exceptions if they provide atypical services after the expiration of the exemption from the routine cost limits.

5. Per Stay Limit for Intensive Needs Residents—The Secretary, after consultation with appropriate agencies, outside experts, including skilled nursing facility experts, shall develop and publish by (date to be supplied late) a per stay limit for residents of a skilled nursing facility who require intensive nursing or therapy services.

6. Budget Neutrality Provision—The Secretary shall adjust payments under paragraph 2 in a manner that ensures that total payments for covered non-routine services under this section are not greater or less than total payments for such services would have been but for the application of paragraph 5. (This provision is intended to make number 5 budget neutral.)

7. Reduce SNF capital cost reimbursement by 5%.

Transitional Payment System Proposal Approved by the NSCA Board of Directors September 30, 1996

Position on Medicare Skilled Nursing Facility Payment and Reimbursement Approved by NSCA Board of Directors, March 12, 1997

Statement of James L. Scott, President, Premier Institute, on Behalf of Premier, Inc.

Mr. Chairman and Members of the Subcommittee, on behalf of Premier, Inc., which represents major integrated delivery systems across the country and one-third of the community hospital beds in the nation, I am pleased to have the opportunity to share our views about Medicare payment policies relating to postacute care services, especially home health and skilled nursing facility (SNF) care. As this Subcommittee well knows, Medicare expenditures for these services have been rising much more rapidly than outlays for most other facets of the program. Moreover, the proportion of Medicare patients receiving home health and SNF care, and the average amount of such care per patient, are rising.

THE ROLE OF THE MEDICARE PART A TRUST FUND

As you know, the President has recommended that Medicare's Part A Trust Fund retain responsibility for paying only a portion of the home health services received by Medicare beneficiaries (i.e., up to the first 100 visits following a three-day hospital stay). All other visits, including those that are not immediately preceded by a prior hospitalization would be paid from the Medicare Part B Trust Fund. While this proposal has been skeptically received in some quarters, we believe that it is quite defensible, especially given the significant changes over time in Medicare's home health benefit and the current status of the Part A trust fund.

However, we also believe that the proposal needs to be modified so that the new financial burdens imposed on the Part B Trust Fund are shared fairly between Medicare beneficiaries and taxpayers-at-large. We believe that a portion of the home health costs that would be allocated to the Medicare Part B Trust fund should be borne by Medicare beneficiaries through inclusion in the Part B premium. In fact, the Blue Dog Coalition Budget recently unveiled advocates this kind of approach. Specifically, it recommends that the transferred home health costs "be counted in the calculation of the Part B premium for all beneficiaries with incomes above $30,000 a year." Premier considers this concept an equitable approach.

BUNDLING POST-ACUTE CARE INTO THE HOSPITAL PPS

For nearly fifteen years, Medicare has paid for inpatient hospital care on a prospective, per-case basis, using a diagnosis-related classification system. In contrast, Medicare has continued to pay for home health and SNF services using a cost-based methodology. The Administration now proposes a per diem prospective payment system for SNF services beginning in fiscal year 1998, and a separate prospective payment system for "an appropriate unit of service" for home health in 1999. No doubt, these proposals are an offshoot of still-unfinished demonstration projects undertaken by the Health Care Financing Administration (HCFA) in the hope of devising separate, prospective payment policies for home health and SNF care. At this point, however, there are many unanswered questions regarding the Administration's proposals. Nevertheless, in our view, the bundling of home health and SNF services into the existing PPS would be far preferable to investing considerable resources in separate, fee-for-service payment methodologies for these services, especially methodologies that result in payment on a per-diem or per-visit basis, rather than on a much more global basis (e.g., per case).

Under a postacute care bundling approach, a hospital could receive a single payment for both the costs of an inpatient stay and necessary postacute services, and would be responsible for ensuring that the patient received all necessary care. Since a prior three-day hospital stay is a prerequisite for Medicare coverage of SNF services, all Medicare-covered SNF services could be bundled into PPS under this approach. Further, since a large proportion of the Medicare beneficiaries receiving home health services have had a preceding hospital admission, these services could also be bundled into PPS. For example, in 1992, about two-thirds of Medicare home health users began their episodes of care within 30 days of being discharged from a hospital. Looking at it another way, a postacute care bundling approach would provide a ready-made way to distinguish between those home health services that are covered under Part A of Medicare and those that are covered under Part B and would be perfectly compatible with the proposal to allocate home health spending between these two trust funds.

In designing an appropriate postacute care bundling methodology, four key tasks would need to be accomplished: (1) defining the bundle of services to be covered; (2)

identifying an appropriate patient classification system for payment purposes; (3) developing a method for determining the appropriate payment amounts and addressing a variety of related issues (e.g., the need for exceptions or outlier payments); and (4) settling the question of which entity or entities should receive payment for the bundled post-acute services. With respect to patient classification, the system of diagnosis-related groups (DRGs) already in use appears to provide a ready-made solution. In fact, a recent study published in the Fall 1996 issue of Inquiry (A. James Lee, Randall P. Ellis, and Angela R. Merrill, "Bundling Post-Acute Care (PAC) with Medicare DRG Payments: An Exploration of the Distributional and Risk Consequences," Inquiry 33: 283–291) concluded that "hospital-level risk actually would be reduced if post-acute care were bundled with the DRG payments for inpatient stays." Of course, over time, it may be necessary to further refine the DRG classification system to account for differences in the postacute care needs—and costs—of patients now classified in the same DRG. However, such refinements would be no different that the many other changes in the classification schema that have already been made for a variety of reasons.

Of course, the bundling of postacute care undoubtedly would raise questions about the impact on quality of care, treatment outcomes, and utilization of services. Morever, consideration should be given to the need for changes in existing Medicare statutory and regulatory requirements, and appropriate beneficiary coinsurance and copayment obligations for the bundled postacute care services would need to be devised.

If payment for postacute care were bundled into the hospital inpatient PPS, the result would be a single responsible entity (the hospital), which would no longer see its obligations to the patient end at the time of discharge. Such bundling would also give hospitals more flexibility in deciding how best to meet a patient's needs, and in what setting. Finally, such a policy would dispel any appearance that hospitals are "gaming" the system when they discharge their patients to affiliated postacute care settings.

In short, while we recognize that bundling postacute care into PPS raises a number of issues, such an approach appears to present clear advantages over continued reliance on per-diem, per-visit or other relatively fragmented payment methodologies, where multiple providers share responsibility and where it is conceivably easier for an individual patient to "fall between the cracks," or for one provider to shift a care burden to other providers, perhaps in response to the incentives provided by Medicare payment policy. While a postacute care bundling policy is initially likely to cover only SNF and home health care, it could eventually be expanded to cover care now received in other postacute care settings. Congress should mandate demonstrations in postacute care bundling policy and assure that at least the same level of resources is devoted to this integrated delivery system approach as has been directed toward other postacute care payment alternatives. This policy would benefit Medicare beneficiaries and would reduce the fraud and abuse in a portion of the delivery system that is so fragmented.

○

ISBN 0-16-055959-6
90000
9 780160 559594